Salugenic Relationships that Rehumanise:

A Grounded Theory of Congruence

Cathrin Ann Ruth Brown

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Abstract

This study is a mixed methods study, conducted in a therapeutic faith community, using quantitative (CGI, SCL-90-R and WHODAS-II) and qualitative interview data that generated a theory of congruence. Early findings demonstrated that context changed the dynamics of the relationship between the researcher and the participants. This led to dissemblance in responses to the outcome measures. A critical realist 'value laden' approach was used which challenges the existing tendency to privilege quantitative over qualitative data by proposing that context and subjectivity are involved in all aspects of interpersonal research.

The theory of congruence proposes that the key to personal positive change is the ability to recognise personal incongruence. Incongruence was identified as a fragmented self, social isolation, crisis of faith and lack of environment 'fit'. Becoming congruent was identified in three areas, a whole self, a social self and a spiritual self. The process of becoming congruent with self begins with external sources that are relationships and environment. These relationships have been termed salugenic (health-producing) relationships, which are voluntary, volitional and mutual. Such relationships resist hierarchy, promoting positive power and autonomy. The theory of congruence proposes that individuals who have been socially isolated learn how to form salugenic relationships that facilitate salugenic emotion.

A congruent environment is where individuals feel they belong, find hope, safety and freedom. It is also a place that is congruent with their beliefs. The combination of congruent relationships and environment leads to the process of finding congruence with self within the context of having personal choice.

The participants in this study were incongruent with professionalised and structuralised services that can be too rigid to meet the needs of the emotionally and mentally ill. Congruence theory can be applied by any organisation to prioritise structure, relationship and choice that rehumanises mental health care.

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Table of Contents

List of Diagrams and Tables

Appendices

Introduction

The National Health Service (NHS) has fundamentally changed through growing demands from improving treatments and survival rates. These are countered by demands from the government to curtail spending and increase efficiency. The economic burden of mental illness is frequently quoted but with varying costs dependent on the factors that have been included e.g. loss of productivity, unemployment, and social care. However, what is significant is that costs are set to double over the next 20 years, a large proportion of which will be due to dementia (NICE-SCIE 2011: p.106; 1983). The figures used in *Mental health promotion and mental illness prevention: The economic case* (Knapp, McDaid & Parsonage 2011) report helpfully separate out the different mental disorders. Their calculations suggest economic cost of £37.7 billion in 2007 rising to £53.7 billion in 2026. If dementia is included the figures increase £48.6 billion (2007) to £88.5 billion by 2026. These figures are based upon treatments, support services and employment remaining the same (*ibid*. p.12). Another specific cost worth noting is that 43% of claimants of incapacity benefit have a mental health problem making this the most common reason to claim. These are of course only the best 'guesstimates' as the personal impact on lives is incalculable (*ibid* p.12).

In the forward of the government white paper, *Healthy Lives, Healthy People* (Department of Health 2010: p.2), it states, 'tackling poor mental health could reduce overall disease burden by a quarter'. Each government strategy has a different way of tackling this problem. However, each strategy addresses issues that are environmental and social in origin. The latest strategy in particular identifies negative environmental effects of post-natal depression, alcohol and drug dependency, employment and homelessness and aims to introduce initiatives to begin tackling these problems (Department of Health 2011: p.39). These are issues that Bonner (2006) also describes regarding the problem of social exclusion. These factors have been recognised in the government strategy on mental health leading to a lifelong approach to addressing the issues starting with post-natal depression, through childhood to old age (Department of Health 2011: p.2). The strategy is socially minded and becoming more preventative and oriented to recovery, this will have an impact on the voluntary sector, including

churches, who offer the services that the government is suggesting (Department of Health 2011: p.52).

In an attempt to shift the focus from illness to wellness the government launched a programme to identify ways of measuring the nation's well-being (MNW). This is being conducted by the Office of National Statistics (2009; 2011). The aim is firstly to identify a set of measures that will provide meaningful statistics to determine 'how society is doing?' One of the aims is to research what factors determine wellness so that these can form the basis of government policy.

The focus of the present study is on Christ Church, which is a non-residential therapeutic community that is also a church whose membership is broad-based. The community is non-clinical and non-selective. It has attracted some members who have emotional and mental illnesses. The concept of therapeutic community and an introduction to the church will be given in chapter one. The researcher will also be introduced in the first chapter. Chapter two introduces the background issues of religion, spirituality and mental health, therapeutic relationships, self and emotion. In order to give greater understanding for background issues the chapter concludes with a summary of the theory developed in the present study. Chapter three presents the quantitative methodology and chapter four the qualitative methodology including the way in which grounded theory analysis is carried out. Chapter five presents the findings of both the quantitative and qualitative methods. In chapter six these findings will be discussed and compared with the wider literature. This chapter will also discuss the implications of the findings. Finally, in chapter seven the conclusions and proposals for future research are presented.

1   Introduction to Therapeutic Communities and Christ Church

This chapter will present the context of the area under study. In order to help describe the context the literature on therapeutic communities is presented first. This is followed by an introduction to Christ Church and how Christ Church is compared to other therapeutic communities. The last section will present the perspective of the researcher.

1.1   Introducing Therapeutic Community

The context in which this study took place is Christ Church based in Deal, Kent, which describes itself as both a church and a 'therapeutic faith community'. Christ Church was founded as a church in 1998. It became a therapeutic community after implicit, unwritten 'social rules' were identified, which had been developed by the membership to maintain structure and boundaries. The community is non-residential and currently the membership is around 50 adults. In order to introduce Christ Church this next section will present the nature and work of therapeutic communities in general.

1.2   The Development of Therapeutic Communities

An early record of a type of therapeutic community is found in the Belgian town of Geel. This record concerns a 14th century legend of a woman called Dymphna who sought sanctuary in the local church from her mentally ill father but was martyred by him. The site of her martyrdom became associated with miraculous cures of mental illness. Subsequently the town community built up a practice of welcoming the mentally ill into the homes of the local families, which became the roots of therapeutic community addressing the basic needs of individuals to feel safe, cared for and non-stigmatised. The local council assumed authority over the process in 1850 and it has become more formalised over the last 150 years and still continues today (Goldstein & Godemont 2003).

In England, around the time Geel was becoming more formally constituted, a reform movement was emerging towards 'moral treatment' and the Retreat in York was established (Kennard & Roberts 1983: p.16). William Tuke, who was a Quaker, founded the Retreat as an alternative to 'madhouses' that often restrained the 'insane'. Its goal was to provide humane residential treatment for the mentally ill through providing a calm social environment with a work focus. Although the concept of 'moral treatment' declined The Retreat continues as a modern therapeutic community today providing services for people with complex mental health disorders such as, personality disorder and eating disorders.

1.2.1   The Second World War and Therapeutic Community

A significant development in therapeutic community occurred during the Second World War. Manning (1989: p.6) writes that the developments in therapeutic

communities were a direct outcome of the war where there were shortages of medical and psychiatric staff and resources and a rapid increase in demand for the services which all required new ways of working.

The government predicted there would be mass psychiatric breakdown as a result of the war and so appointed a psychiatrist with psychoanalytic training, J.R. Rees (1943) from the Tavistock Clinic, to become Head of the Army Psychiatric Services to develop new ideas and new ways of working. This in itself did not give rise to therapeutic community but opened the way for new psychotherapeutically informed ideas to be developed.

Kennard and Roberts (1983: pp.41-7) describe the history of the Northfield Military Hospital and psychiatrist, Wilfred Bion who been appointed to bring discipline and order. Instead he introduced radically new ideas on patient responsibility, which were too extreme for the commanding officers. He was replaced by Tom Main. Main learned from the previous mistakes by introducing changes more slowly and working with the officers. Main was the first person to coin the term 'therapeutic community' in the UK. Meanwhile in a separate development Maxwell Jones (1974: p.1) was working at Mill Hill hospital treating patients with 'effort syndrome'. He describes having 100 men with the condition and through necessity decided to educate the patients about their condition through a series of lectures. These patients became so enthusiastic that they began to educate the new patients. Jones observed this behaviour and began to experiment with a more democratically run hospital environment.

Writing in 1946, Tom Main suggests the goal of a hospital therapeutic community should not be a social retreat from everyday life, because that only leads to a partial recovery. Rather social interactions and personal responsibility would be brought into the hospital setting generating a real community where the doctor no longer 'owns his patients' (Main 1989: p.9). He goes on to write that the medical doctor finds it hard 'to renounce his power' (*ibid* p.10), as it is much too easy to resort to authority, imposing law and order from above so that situations are controlled and managed instead of explored and discussed.

Main recorded his discussions with nurses about the use of sedatives and observed that the nurses were administering sedatives to their patients because

they were hiding behind 'pharmacological traffic' (*ibid* p.13). This is because the nurses had not been allowed to voice their own feelings about the difficult situations. Main describes the difficulty medical staff experienced in becoming open about their feelings (*ibid* p.17). Main suggests that the medical doctor is not trained to study medicine of the whole man, but only to be a 'parts specialist' (*ibid* p.67). The new approach of the therapeutic community required a complete reversal on how medical professionals are trained and expected to perform.

Denis Martin (1968: p.111), at Claybury Hospital, also came to similar conclusions and suggested that the doctor 'must see himself as a servant of his staff rather than their master'. The latter chapters of his book are concerned with assertions that the church needs to be a therapeutic community.

1.3   Defining Therapeutic Community

The definition of therapeutic community is complex due to the variety of different types of therapeutic community. Modern therapeutic communities are most commonly specialised, for example, addiction (Goethals et al. 2012), child and adolescent disorders (Carter, J. 2011) , personality disorder (Chiesa & Fonagy 2000) and prison institutions in the treatment personality disorder (Rawlings 1999) and substance misuse (De Leon, Melnick, et al. 2000). There are modified therapeutic communities (De Leon, Sacks, et al. 2000) and day therapeutic communities (Barr et al. 2010). These are a few examples of the different types.

The body responsible for developing the standards and profile of therapeutic communities in the United Kingdom is the newly re-named The Consortium for Therapeutic Communities (TCTC), formerly the Association of Therapeutic Communities (ATC). The TCTC collaborates with the Royal College of Psychiatrists, Community of Communities project, to develop the standards of practice and peer review standards. The definition of a therapeutic community used is;

> 'A treatment programme where a range of activities, including specific psychotherapies and social interaction, form the treatment programme. The group relations and the community itself, rather than any single element, form the primary therapeutic agent. Membership is clearly defined, and staff have a facilitative role. To be recognised and commissioned, they should meet quality

standards from the Royal College of Psychiatrists Centre for Quality Improvement ('Community of Communities'), and also meets NHS commissioning standards if accredited' (Association of Therapeutic Communities n.d.).

A description of the different types is presented first followed on by an introduction to the core values of a therapeutic community.

1.3.1 Types of Therapeutic Community

A useful introduction to therapeutic communities is provided by both Kennard and Roberts (1983) who attempt to define therapeutic communities by four main categories, but admit that in practice therapeutic communities will be a combination of more than one type. The four types are,

- Institutional
- Democratic-analytic
- Concept-based
- Alternative asylum-anti-psychiatry

The institutional therapeutic community is described as large institutions transformed from 'containers for the chronically mentally ill' to more socially informed 'humane' hospital still run by doctors and nurses but in a less authoritarian structure (Kennard & Roberts 1983: p.6). Democratic-analytic therapeutic communities tend to be smaller communities in which decisions are made by the whole community and where the hierarchy between staff and patients is flattened (*ibid*: p.6).

The 'Concept-based' therapeutic communities are also small but there is a clear, and sometimes authoritarian, hierarchy. They were often staffed by former residents and used no or very little professional services and more recently changed away from the original concept of using former residents as staff and introduced more trained and professional led services (*ibid*: p.6). These therapeutic communities are associated with alcohol or drug dependency (Soyez et al. 2004; Goethals et al. 2011).

The last category is described as 'alternative asylum' or 'anti-psychiatry' therapeutic community and are made up of people disaffected by conventional

psychiatry (*ibid*: p.7). These are grouped together by common ethos, such as tendency to be anti-labelling and resist staff/patient boundaries and are often based on spiritual, moral and social models of emotional distress.

In the USA there is another type of therapeutic community model, the Sanctuary Model. This type of therapeutic community is open to people with a variety of backgrounds including domestic violence, psychiatric disorders and posttraumatic stress disorder (PTSD) (Wright & Woo 2000; Bloom et al. 2003; Madsen et al. 2003). This model is based on four pillars of knowledge which are: psychobiology of trauma, active creation of non-violent environments, principles of self-learning, and understanding ways in which complex adaptive systems grow, change and alter. In applying this model to acute psychiatry the outcomes were measured over two years and resulted in a 87% reduction in seclusion rates (Bloom et al. 2003).

In the United Kingdom many of the therapeutic communities are associated with personality disorder and prison populations of severe and dangerous personality disorder. In an attempt to try to define commonalities between such diverse communities research into core values has been carried out.

1.3.2 Developing Core Values

In his introduction to *Beyond the Therapeutic Community*, Maxwell Jones (1968) states that the growth of community psychiatry had outstripped their knowledge. He was looking to the future possibilities of being able to validate therapeutic communities whilst acknowledging the vagueness of the current practices (Jones, M. 1968: p.ix). At the Henderson Hospital, Jones invited sociologists led by Rapoport to research the therapeutic community. The qualitative findings became the most popular quoted source and formed the basis of future research through identifying the four themes (Rapoport 1960: p.54) of therapy, which were;

- democratization
- permissiveness
- communalism
- reality confrontation

'Democratization' referred to the decision-making processes in the therapeutic community and 'permissiveness' pertained to tolerating a wide degree of

behaviour. 'Communalism' referred to the tight knit relationships and informality. The meaning of 'reality confrontation' was that patients should be continuously confronted with their behaviour as seen by others. However, the results were much broader than this and identified 30 different 'postulates'. Also noteworthy is that they found mixing patients with different diagnoses on the same wards to be more successful than homogenous wards. Having a mixed group of people allowed for different strengths and weaknesses to be identified and provide balance, termed the 'balanced aquarium' (*ibid:* p.284).

In summing up the findings of this study Rapoport attempted to answer which patients benefit from the 'therapeutic milieu'. His conclusion was that the instruments required would be very difficult to design because of the 'multiplicity of factors' involved (Rapoport 1960: p.282). The wide variety of communities and practices adds to the difficulty of trying to determine the importance of the social milieu and the psychotherapeutic treatments on offer (Manning 1989: p.6). Rapoport also concluded that complete permissiveness is just as harmful to the therapeutic relationship as coercion and conformity (*ibid* p.286). This was a postulate later back up by Williams (2007: pp.109-10) who identified the delicate tension between safety and freedom which is optimal for producing a change environment.

The key essentials of a therapeutic community identified by Rapoport (1960) were further researched and elaborated on by Haig (1999). He proposed this is the 'quintessence' of a therapeutic community:
1. Attachment: a culture of belonging
2. Containment: a culture of safety
3. Communication: a culture of openness
4. Involvement: a culture of participation and citizenship
5. Agency: a culture of empowerment.

The quintessence has been used the basis of the core values within the UK. Holmes (2005: p.216) proposed a sixth dimension of 'with Christ in our midst' for Christ Church.

In all therapeutic communities these qualities are present to some extent, but each of the values may be compromised by the treatment priorities. This is evidenced

by the study conducted to ascertain what importance therapeutic communities attributed to certain characteristics (Melnick & DeLeon 1999). The study was designed around an instrument called the Survey of Essential Elements Questionnaire (SEEQ). This instrument is a self-report questionnaire given to two different types of therapeutic community, traditional and modified (concept-based). A simple statistical comparison was made between the scores from both sets of therapeutic communities in order to identify characteristics that both held in common. The results of the study demonstrated that whilst there was high agreement in the common essentials there was greater disparity in how important those essentials were in the treatment programme, in particular the importance of the community as therapist. The weakness of the study was that the questionnaire was given to the directors of the therapeutic communities to obtain their views about the importance of certain characteristics, rather than consult with members who may have differing views.

A critique of therapeutic communities was published by Zeitlyn (1967) who asked pertinent questions for the therapeutic community movement. In particular he challenged the notion of a flattened hierarchy. He accurately reported that therapeutic communities were founded as an alternative to the structured hierarchy of the medical ward models. He suggested that there was the risk of replacing the doctor (whose role was supposed to be harmful) with a 'leader' so perpetuating the hierarchy. In addition the use of the terms junior and senior staff, indicating length of service or experience, can also become hierarchical. The admission process led to rejection of some people and hence discrimination, because they were deemed unsuitable for the therapeutic community environment.

1.4   What is Therapeutic About Therapeutic Communities

From the origins at The Retreat and 'moral treatment', the social environment was considered to be the most important aspect for recovery. For Maxwell Jones at the Henderson hospital there were three aspects of therapeutic community, 'community meetings', 'staff review meetings' and 'living-learning situations' (Kennard & Roberts 1983: p.50). The latter became 'social learning' that Jones proposed as an alternative term to 'therapy' (1974: p.7). He suggests that using the term 'therapy' limits 'us to psychopathology and the medical model' (*ibid*: p.7)

whereas 'social learning' can include psychotherapy, social interactions and the social environment. He defined 'social learning' as 'two-way communication in a group, interaction motivated by inner some need or stress, leading to overt or covert expressions of feeling, involving cognitive processes and change' (*ibid*: p.7).

Jones' ideas on social learning have formed the basis for therapeutic community practice that has been defined as sociotherapy and psychotherapy (Whiteley 1986), where sociotherapy is behavioural change that results from relearning social roles and from interpersonal interactions in addition to the dyadic relationship in psychotherapy. It is concisely described as personal change in a group context (Melnick & DeLeon 1999).

The Consortium for Therapeutic Communities' (TCTC) (2014) define 'community is the primary therapeutic instrument' where 'group dynamics' and interactions are used as a tool to highlight the individual's needs. This 'social learning' can be facilitated by trained staff and by other service users or 'experts by experience'.

Therapeutic communities for personality disorder mentalization based therapy (MBT) (Bateman & Fonagy 1999, 2004) is often used alongside 'community meetings' that are described as 'group processes' (Hinshelwood 1987) and can be psychotherapeutically informed. As DeLeon (2000: p.8) states therapeutic communities are all diverse and use many different therapies. For example in concept communities, 'encounter groups' are usually used, which are groups used to confront the behaviour of one another. Therapeutic communities may employ many different professionals such as social workers, psychologists, nurses, psychiatrists and psychotherapists. As an example, Crockford, Brunton and Surgenor (2003) describe a psychiatric day hospital run on therapeutic community lines that uses psychodynamically informed small group processes and individual approaches of symptom based and skills based work. The aim was to firstly provide containment and symptom relief and then to address the underlying issues.

1.5 Outcome Research in Therapeutic Community

The therapeutic nature of therapeutic communities can lead to either psychological research interested in the individuals or sociological research interested in the social processes and systems (Morant & Manning 2005). The goal of therapeutic community research has often been driven by the need to establish an evidence base asking the question 'does it work?' In order to answer this question Kennard (1979: p.298) posits three areas as pivotal to finding an answer, defining the community, defining what success means, and describing the clientele. Therefore the extent to which the overall question of 'does it work?' can be answered depends on the extent to which the three sub-questions can be answered.

Nick Manning (1979: p.291) suggested two reasons for why therapeutic community research was not forthcoming. Firstly, the external pressure to continue to provide a regular service and secondly, the internal self-satisfaction that the basic idea had been sufficiently developed. This is despite the call to conduct research by those more active in the field (Ravndal 2003; Lees, Manning & Rawlings 2004; Morant & Manning 2005). The difficulties with researching therapeutic communities are: choosing suitable outcome measures, ambivalence towards adopting an evidence-based approach, along with higher costs as a consequence of a higher ratio of staff to patient and higher ratio of space per patient that have hindered the reputation of therapeutic communities in wider psychiatry (Manning 1979: p.289). The very culture of a therapeutic community, that is to say the core values, can also be a barrier to wider acceptance. However, over the last decade the Centre Quality Improvement unit of the Community of Communities project at the Royal College of Psychiatrists in collaboration with the TCTC, has begun to have a significant impact by increasing the research being carried out within therapeutic communities in order to better understand the essential characteristics that determine good practice and outcomes.

In a meta-analysis of effectiveness research conducted in therapeutic communities for personality disorder the authors found 29 outcome studies dated from 1960 until 1998, this included eight randomised controlled studies. The conclusion was that there was some statistical positive treatment effect but that overall the differences between communities and low quality of research weakened the overall effects (Lees, Manning & Rawlings 2004). The authors specifically identified the difficulty of measuring endpoints in the studies.

A report into service provision for personality disorder concluded that therapeutic communities could be seen as centres of excellence (National Institute for Mental Health in England 2003). This was later followed by The National Institute for Health and Clinical Excellence (NICE) (2009: pp.175ff) treatment guidance for borderline personality disorder, which proposed therapeutic communities as a possible course of treatment. However this guideline also comments that cost effectiveness of therapeutic communities for personality disorder has not yet been established and further research needs to be carried out (*ibid* p. 207).

Outcome research, using the Borderline Syndrome Index (BSI), for borderline personality disorder treatment at the Henderson hospital concluded that specialist in-patient treatment was effective in reducing psychopathology up to one-year after discharge (Dolan, Warren & Norton 1997). Outcome research based on the Global Assessment Score (GAS) and Social Adjustment Scale (SAS) was carried out at the Cassel Hospital that focuses on treating personality disorder established a small evidence base for this work (Chiesa & Fonagy 2000). In a mixed methods study at the same therapeutic community important factors contributing to early termination of treatment were identified (Chiesa, Drahorad & Longo 2000). The authors used the symptom checklist-90 (SCL-90), social adjustment scale (SAS) and global assessment scale (GAS). A different approach was taken in a study on the Francis Dixon Lodge a therapeutic community for personality disorder (Davies & Campling 2003). The authors monitored hospital admissions, and use of mental health services for three years after discharge from the community and found a reduction in usage linked to successful engagement with treatment in the community.

In Norway there have been outcome studies demonstrating the effectiveness of day units for personality disorder using global assessment of functioning (GAF), symptom checklist 90 items (SCL-90), quality of life (QoL) scales (Karterud et al. 2003; Karterud & Wilberg 2007; Pedersen & Karterud 2007).

Outcome research was conducted on a day hospital run on therapeutic community lines using the measures, Inventory of Interpersonal Problems-32 (IIP-32), Brief symptom Inventory (BSI) and the Health of the Nation Outcome Scales (HoNOS) (Crockford, Brunton & Surgenor 2003). This research provides an illustration of

follow-up appointments being made out of clinical need and not research need that resulted in fewer data collection. Improvements were found that were measured up to three months after discharge.

A mixed methods study carried out and reported in two papers by Barr (2010) and Hodge (2010) was conducted on a once-weekly therapeutic community for personality disorder. The researchers were able to demonstrate statistically significant improvements using quantitative outcome measures and to triangulate with qualitative data obtained from semi-structured interviews and analysed by thematic content analysis.

In the USA 'The Sanctuary Model' of therapeutic community working with traumatised children and adults has generated some outcome research (Wright & Woo 2000; Bloom et al. 2003; Madsen et al. 2003). The Program for Traumatic Stress Recovery (PTSR) in Canada is a therapeutic community based on the Sanctuary model and incorporating the research on trauma and posttraumatic stress disorder. Originally intended as a therapeutic community for victims of childhood sexual abuse it has grown to encompass any person with posttraumatic stress disorder (PTSD). An outcome study was conducted to determine the effectiveness of the therapeutic community program by measuring changes on the Symptom Checklist 90 items revised (SCL-90-R) and Clinician Administered PTSD Scale (CAPS) (Wright & Woo 2000). The therapeutic community has a clear six-week treatment program within a residential setting. The outcome measures were collected on admission, at discharge, 3 months and one year. The results demonstrated a long-term improvement using these measures. However, the graph data were incomplete and the statistical data were not presented.

In assessing the importance of this research it is useful to note Manning's (1979: p.303) comment that measuring outcome is only one of the goals. He states four areas of important research for therapeutic communities.

1. Compare large numbers of therapeutic communities to suggest relationship between the variables.
2. Study individual aspects and how they work together.
3. Study natural fluctuations over time.
4. Attempt to delineate individual requirements of each patient or each type of patient.

By studying each of these four areas a bigger picture on what constitutes a therapeutic community will emerge that will then enable better outcome research to be carried out.

The outcome research presented is mainly focused on personality disorder and on therapeutic communities that operate with a distinction between staff and clients, and usually for a limited treatment course. Personality disorder (PD) is associated with other types of morbidity and therefore outcome measures used are often broad based. It is reasonable to assume that the outcome measures used in these studies would be applicable to the present study.

Summary

This section has introduced the concept of therapeutic community and the diversity in types of treatment and structures associated with them. This makes a universal definition of a therapeutic community very difficult. Instead core values have been developed.

In the next section the area under study, Christ Church, Deal, will be introduced and compared with the core values and definition of therapeutic communities presented above.

1.6 Introducing Christ Church, Deal

This section will introduce the history of Christ Church and the previous research conducted in Christ Church. In this section the ways in which Christ Church can be considered as a therapeutic community and how it differs from other therapeutic communities will be presented. Christ Church is an 'open' therapeutic faith community. It is 'open' as it does not have a residential centre, members live in their own homes or in shared accommodation. It does not have strict criteria for admission. It is 'open' in that members have their work or studies outside of Christ Church. It is 'open' in that as a church the Sunday morning service is a time open to public for worship.

1.6.1 History of Christ Church, Deal

Christ Church was founded in 1998 with 25 adults and 11 children. The church's charitable status is constituted on the basis of the providing relief to persons who

are in conditions of need or hardship, or who are aged or sick, and to relieve the distress that these conditions cause.

The church was formed by a group of individuals who were currently being pastorally and therapeutically supported by Peter Holmes. An eldership model of five men and no paid full-time leader was adopted. The Elders decided to base Christ Church on three principles of worship, biblical teaching and wholeness. Peter Holmes had been developing a model of one-to-one 'therapeutic discipleship journey' for over 30 years and was invited to provide some pastoral care and teaching (although not on a full-time basis). Susan Williams was responsible for the women's pastoral care. The essence of the 'discipleship journey' is a combination of emotional healing and deepening personal faith in God, discussed in more detail when describing Holmes' doctoral thesis below. Christ Church is a member of the Evangelical Alliance, registered as a therapeutic community with the Royal College of Psychiatrists Community of Communities and a member of The Consortium for Therapeutic Communities. Aware of the needs of the members the Trustees of Christ Church appointed a Risk Management team of comprised of suitably qualified professionals such as mental health and social care professionals, to manage instances of risk to members of the community. Such instances were threatened suicides or self-harm, and child safeguarding issues. The pastoral teams manage other issues presenting less risk.

From its inception Christ Church experienced rapid growth from churchgoers and non-churchgoers, locals and those who moved to Deal to join the church. For some members Christ Church was seen as a place of 'last resort' having unsuccessfully sought help from various agencies or organisations. With the growth in membership there was change to the leadership structure in Christ Church. The original Eldership of five men became a democratically elected leadership team of 20 (ten men and ten women) in order that as many different groups in the church as possible could be represented.

Present status

The demographics of Christ Church were documented in Williams' (2002: p.98) research showing an age range of 20-40 years with equal numbers of men and women. Since then the overall membership has fallen from its peak of 150

members to 72 adults and 33 children (July 2012). This has been reflected by the current status of a smaller Eldership team to provide the spiritual direction and covering, with the church membership volunteering to cover practical activities. The church community has retained flattened structure by not employing paid pastoral staff. The only paid staff in the Church are the administrative team in the church office. The flattened structure is similar to that seen in democratic therapeutic communities as it encourages wider participation and responsibility from the membership. However, there is an informal hierarchy based on growing experience and maturing faith.

1.6.2 The Therapeutic Discipleship Programme

At the same time as the founding of Christ Church, weekend workshops called *Rapha* workshops were introduced to teach principles of personal wholeness and discipleship to members of Christ Church as well as non-members. *Rapha* is a Hebrew term meaning healing and wholeness and is foundational to the therapeutic journey. This development arose out of a need to reduce a growing waiting list of people wanting help and support from Peter Holmes and Susan Williams. The workshop ministry is called *Rapha* Ministries in the UK and *Rapha Journey* in the United States. The principles taught at these workshops can be found in Holmes' (2004) published thesis described below. The workshops are mainly taught by Peter Holmes and Susan Williams, but other experienced members of Christ Church also teach. Christ Church members are encouraged to be involved in the organising and running of the workshops through administration, catering and supporting workshop participants.

At this time people discovered *Rapha* ministries and Christ Church by word of mouth. Susan Williams' journey of personal healing was published as *Passion for Purity* (2000) and subsequently re-published as *Letting God Heal* (2004). This autobiography describes her journey of healing from emotional breakdown through support from Peter and Mary Holmes. The book illustrates how the current principles and concepts of a discipleship model of wholeness developed and are taught at *Rapha* workshops and within Christ Church. This book along with meetings at which Susan Williams shared her story positioned *Rapha* ministries and Christ Church as a ministry for teaching and supporting for those with mental

and emotional illness. The book was another way in which people discovered *Rapha* and Christ Church*.*

Rapha ministries has held workshops around the UK and internationally, for example, USA, Turkey, Rwanda and Germany. Individuals who continue contact with the workshops, Christ Church, and Peter Holmes and Susan Williams view themselves as part of an informal *Rapha* Community. Outside of Deal there are a number of *Rapha* discipleship groups comprised of varying numbers of individuals who have attended *Rapha* workshops and meet with others living in the same locality to offer ongoing relationships and support. Members of *Rapha* discipleship groups who have a faith continue to belong to their local church whilst conducting their own therapeutic discipleship journey. For many, as their personal relationship with God deepens, their aim is to be able to participate more deeply in their local church ministry.

The core of the therapeutic work is based around teaching from workshops, one-to-one mentoring, and occasional in-depth individual diagnostic counselling sessions (Holmes 2004: p.227). These counselling sessions are usually conducted by Peter Holmes or Susan Williams. As experience grew in the discipleship journeys and mentors were introduced there was less demand for individual counselling sessions. There is no set programme for receiving diagnostic counselling sessions. These sessions are requested by the mentee or mentor when either party feels they need third party perspective and support. A newcomer may receive a weekly session if required and long-term members may request sessions rarely. It is dependent on personal circumstances and need.

1.6.3 Mentoring and Troikas

The mentoring system was based on ideas and concepts such as character virtues of integrity, courage and care, (Wilson & Johnson 2001). Instead of focusing on life-long relationships, mentoring is practiced as the 'passing on of personal experience' (Holmes 2005: p.143) Appropriate training is given to Christ Church members who would like to become mentors. In Christ Church mentors are experienced same-sex members who can support others in their journeys by virtue of being 'one-step-ahead'. The community define 'one-step ahead' as someone who has experienced dealing successfully with at least one issue in their

lives and can share this experience with others. For multiple examples see *Changed Lives* (Holmes & Williams 2005) a book presenting individual's stories of issues such as addiction, marriage difficulties, and mental illness.

Mentoring was later supplemented by '*troikas*': a system initiated and favoured by the men. The word *troika* comes from the Russian way of harnessing horses three-a-breast. In Christ Church a '*troika*' is three people supporting each other equally and mutually, and differs from mentoring where the mentor is generally accepted to be 'one-step ahead' in their journey compared to the mentee. Mentor relationships generally have a sense of continuity whereas 'troikas' can come together for single meetings. A mentor is usually chosen by a mentee but sometimes allocated particularly for newcomers. Choice is often made on the basis of the mentor's personal story as the mentee will choose someone who has had a similar experience to his or hers. A mentor and mentee will typically meet once weekly. 'Proxy mentors' are people who could 'fill in' if their regular mentor was unavailable. They are also chosen by mentees as persons who they consider to be trustworthy.

1.6.4 'Experts by Experience'

The relationships in Christ Church are not professional ones but are described as 'experts by experience' a term commonly used in the therapeutic community movement (see section 1.4). This is not just 'experts by experience', but 'experts by the experience of experiencing personal positive change'. Also, they are strictly not 'experts' as the emphasis is on life-long journeying. They are relationships that form out of understanding the other person, not just empathising which has been called '*verstehen'* (Benton & Craib 2001: p.73). They are relationships that Martin Buber (1937) calls I-Thou because they are formed out of mutual experiences.

It is expected that all members will eventually become 'experts by experience' and become mentors or participate in troikas, so increasing the 'mentoring group IQ' that 'now represents hundreds of years of therapeutic success and failure' (Holmes 2005: p.143). Mentoring contributes to pastoral care and helps to ensure that personal responsibility for self and for others is maintained as a core principle.

1.6.5 'Social Rules'

The membership of Christ Church had doubled within the first twelve months, which prompted an invitation to Sara Savage, who was at the time a Senior Research Associate for Psychology and Christianity Project at the Faculty of Divinity, Cambridge University, to visit the community. Sara Savage had been a supervisor for Peter Holmes' Masters research and had familiarity with Christ Church. Over the course of a weekend she identified some unwritten 'social rules' that guided relationships that the church membership had developed to define its therapeutic processes. This was reported back to the Christ Church Leadership team (Savage 2001). The 'social rules' were common phrases used by members of the community at the time, 'cut the crap', 'it will hurt like hell but it is worth it', 'tell the truth, they already know', 'drop the religion', 'do not judge', and 'its ok to cry'. As a result Savage suggested that further research could be done to understand the social processes.

1.6.6 Congregational Research in Christ Church

Spurred on by the finding of 'social rules' in Christ Church both Peter Holmes and Susan Williams began academic studies. In 2002 Susan Williams completed her Master of Philosophy on *Journeys of Personal Change: A Congregational Study of Christ Church Deal*. This dissertation focused on the 'meaning' of Christ Church to its members using an ethnographic methodology. One of the key findings was that the participants considered Christ Church to be a community (Williams, S. B. 2002: p.31). The findings showed that participants were proud to call Christ Church a therapeutic community rather than a therapeutic church (*ibid*: p.37). They described the key to the therapeutic journey as the relationships in the community (*ibid*: p.39). The added dimension to Christ Church is that it is a 'therapeutic faith community' (*ibid*: p.45). Williams found that some participants held resentment towards previous churches for the pressure to convert others and welcomed the "permission to be angry with God" (*ibid*: p.40). Williams' findings suggested that although there was some reluctance to call Christ Church a church, most participants would not have joined if it had just been a therapeutic community and they wanted the spiritual dimension to the community. Christ Church had not been founded as a therapeutic community but had the hallmarks of a therapeutic community being focused on social processes for healing.

The main findings of this research were that Christ Church has a culture of facilitating personal change that is dependent on acceptance, truth and transparency. Participants felt accepted for who they really were in a social environment that 'normalised stigma' (*ibid*: p.74-80). Participants were able to dismantle their 'unhelpful' church histories and begin to create a new self that was 'not focused on a God who requires a certain standard of life to be maintained' but of 'wanting God to help them with their identity crises' (*ibid*: p.84). The participants' previous church experience is quoted as:

> 'of a static view of God, leading to a static church, which behaved as if it had the right to 'judge' others against a 'right' way… Christ Church offered a relationship-based community, dedicated to helping the individual change (*ibid*: p.85).

1.6.7 Theological Research and the *Rapha* Model

Peter Holmes' theological doctoral thesis was completed in 2004, *Becoming More Fully Human?: Exploring the ecotone of human spirituality, salugenic discipleship, and therapeutic faith community.* Holmes' key proposals were that sin is the unwillingness to change to become more like Christ (2004: p.368) and that the church can be a change agent (*ibid*: p.370). He adopted Hebrew perspectives on personhood, spiritual community and of emotion. Hebrew personhood is viewed as a single un-differentiated psycho-physiological oneness, body-spirit unity. Holmes suggests that giving human make-up a spiritual dimension avoids the 'sterility' of biological determinism and gives both Christians and non-Christians a way of expressing their spirituality *(ibid*: p.367). The definition Holmes used to best describe the spirituality that Christ Church members held was spirituality based on meaning, value, transcendence, connecting and becoming (Martsolf & Mickley 1998). Spirituality in Christ Church is therefore 'transforming spirituality' through a journey of Christ-likeness and discipleship (*ibid*: p.64). The Hebrew view of spiritual community is that of a communal sense of self with God at its centre, *theocentric*.

> 'In CCD [Christ Church] we seek to live with this Holy God in our midst, for we believe that without Him at the core of human community no one can be truly whole, real ...more fully human…' (*ibid*: p.283).

Community members describe transforming spirituality as the need to change *(ibid*: p.9).

> 'Therapeutic change is the letting go of sometimes toxic painful experiences of our past, by a journey, that allows us to both become more human, who we are created to be, while also more like Christ' (*ibid*: p.43).

Personal positive change is at the heart of the discipleship journey rather than coping.

One of the key principles in the therapeutic discipleship journey is learning to connect with one's emotions described as 'feeling is healing' (*ibid*: p.63ff). A person learns to engage emotion with others in order to 'let it go' similar to the 'flooding' or 'reliving' process in trauma based cognitive behavioural therapy. The Hebrew view of emotion proposes all emotion has a good and bad side and is located in the physical and spiritual dimensions (*ibid*: p.371). This view allows a person to be able to 'cleanse toxic emotions' and 'discover the righteous dimension to our feelings' (*ibid*: p.271).

> 'The goal of the *Rapha* model is the person's personal positive change, by meeting Jesus, letting go of their pasts and being able to extend their capacity to become full member's of Christ, church and community' (*ibid*: p.217).

The goals of the *Rapha* model are achieved through Christ Church giving hope and the individual personally making the choice to change. A person within the community learns 'both to hear their inner voice and learn hope from others on a daily basis through the social process (*ibid*: p.222).

Holmes (*ibid*: p.377) proposed that definitions of health needed to be God centered. In practice Christ Church views psychology as additional understanding of the human state and therefore is psychologically informed. Holmes' (*ibid*: p.374) view is that a division has occurred between psychology and the spiritual; instead the church needs a new 'clinical relational pastoral theology'. The model of wholeness practised in Christ Church is defined as a 'therapeutic discipleship journey' developed from the integration of pastoral care, psychology and practical theology. These principles form the foundation of the journey towards wholeness

through what he termed 'salugenic discipleship' (*ibid*: p.45). Holmes derived the term from Clinebell's (1984) description of pathogenic religion to describe harmful religion. Holmes also used salugenic (health or wholeness generating) to describe, spirituality (*ibid*: p.71), discipleship journey (*ibid*: p.154), change (*ibid*: p.154) and creativity (*ibid*: p.183). He goes on to state that it is *koinonia* (the natural bond of fellowship in the Holy Spirit) relationships that significantly positively impact outcome (*ibid*: pp.262-5). This statement was made based on the comparison between working with a one-to-one model and with the social process in Christ Church. The dynamic in this relational process is Holmes' definition of a 'therapeutic faith community' (*ibid*: p.262).

1.6.8 Sociological Research in Christ Church

In 2007 Susan Williams' doctoral thesis was completed on *The Salugenic Place: Relationships that empower transformative change.* This grounded theory study conceptualises the key social processes involved with personal and community change in Christ Church. Core concepts that emerged in the findings were that the 'trapped self' can result from fear of change, change-despair and 'change resistance' that is primarily explained by experiencing 'prejudicial judging' (Williams, S. B. 2007: p.63). Williams describes two types of 'trapped self' as either 'conforming' or 'defying' (*ibid*: p.72). In answer to the question How can I change?, participants identified two areas of importance, the community or environment that Williams called the 'salugenic Place'. 'Place' is defined as a socially constructed place, not physical, and with a sense of continuity and is something to belong to (*ibid*: p.83). The process of change in the 'salugenic Place' called 'empowered change' (*ibid*: p.77). The 'salugenic Place' was characterised by the tension between the environment providing both safety and freedom (*ibid*: p.102). 'Empowered change' emerged from characteristics such as 'receiving acceptance' and 'being me' so that they no longer felt 'discreditable' (*ibid*: p.142). Empowered change was 'mutual' and resulted in a 'shared becoming' illustrating the importance of relationships in Christ Church and the process of journeying together.

Peter Holmes and Susan Williams published *Church as a Safe Place* (2007). This book provides accounts from people who have suffered from spiritual abuse and provides a biblical, sociological and psychological basis for proposing how to make

church a safer place. Many of these accounts are from Christ Church members. From personal accounts this book identifies types of abuse and proposes a model of leadership and pastoral care that can help to create a safer environment.

Meeting Jesus Together (2010) was published by Susan Williams and Peter Holmes as a guide to starting communities and groups based on *Rapha* and Christ Church principles. This is the first book that uses the term salugenic widely throughout the text and where the term 'salugenic relationship' is first coined (2010: p.193). Using the term salugenic relationship is a natural progression from its first use as 'salugenic discipleship' and 'salugenic Place'. Williams and Holmes (ibid: p.195) propose that salugenic relationships have two characteristics, they are mutual and 'journey together'.

The most recent research was a narrative study of two members of Christ Church (Clarke 2011). The study demonstrated how the narrative culture of Christ Church was used to generate change as a recursive social process.

1.6.9 Activities in Christ Church

The premise is that all activity and relationships can result in therapeutic change, where the meaning of therapeutic is personal positive change (Williams, S. B. 2002: p.31). There is no distinction between an activity that is generally labelled non-therapeutic, such as cleaning and that considered as therapeutic such as a counselling session. This means that all activity and all relationships in Christ Church can be considered therapeutic. In this way the use of therapeutic within Christ Church is more akin to the dictionary definition of having a good effect on body or mind rather than the clinical terminology. The Oxford English Dictionary definition of therapeutic is as an adjective to describe '1. Relating to the healing of disease, 2. Having a good effect on the body or mind' (*Compact Oxford English Dictionary for Students* 2006). Whereas *Blackie's Compact Etymological Dictionary* (Cunliffe 1920) defines therapeutic as 'to tend, treat medically, of or pertaining to healing'. In this thesis the word therapeutic will be used meaning healing rather than pertaining to treatment.

Planned activities

Christ Church is an open therapeutic community with no residential building. Activities take place in a hired local community centre, at 'Waterfront' the home of Susan Williams or in members' own homes. There is no typical day or week in Christ Church; however, there are planned annual and weekly activities.

In July for the town carnival and in December for Christmas an open-top bus is hired. At Christmas it is driven around the streets in Deal with singers on the open deck singing Christmas songs and carols and inviting locals to join the church's 'Christmas Celebration'. The Christ Church Christmas bus is invited to participate in the 'Deal Churches Together' 'Carols on the Green'. The Summer Carnival in Deal attracts a large number of visitors to Deal. Christ Church has taken part in this since 2000. This public presence has attracted some locals to join the church. These events have become a tradition for Christ Church and for the town.

As well as the annual bus events and workshop programme there are planned activities each week. Sunday is the opportunity for the whole community to meet in a local community centre that was formerly a church. The morning begins with 'circle time', which is a time of prayer and worship followed by refreshments. The main service follows during which there is opportunity to share personal testimony. The 'notices' are the opportunity to share community news, celebrate birthdays and achievements, such as moving house or a new job. Every six weeks there is a Community Business Meeting after the main service. This is a time for members to engage with the practical running of Christ Church such as special events and finances.

During the week there are various meetings, a women's meeting on Wednesday evenings open to all women, and an open men's meeting on Thursday evenings. The men's and women's meetings are times to engage with difficult issues at an emotional level and receive support from others. 'Meeting Point' is a weekly mixed gender meeting with no fixed time slot, the time and day is decided at the previous meeting. Meeting point has no fixed agenda, all members are welcome to come and share an aspect of their journey. During the day there are times to come and share coffee and cake at Waterfront, hosted by members of the community. There is a Friday morning prayer meeting at 6.30am led by one of the Elder's to pray for

specific issues that have arisen in the week or events that might be happening over the coming week. All these meetings take place at Waterfront.

Unplanned activities

Other activities take place within member's own homes such as informal meals, meeting for coffee, babysitting and practical ways of helping each other. Members might ask for help with gardening, cleaning or moving house. There are also birthday parties, celebrations and BBQ's. The emphasis in Christ Church is on inclusive social events for the whole community.

1.6.10 Joining and Leaving

Christ Church does not have admission criteria or residential centre and therefore it can be described as an 'open therapeutic community' that welcomes anyone. The members' definition of therapeutic means that Christ Church attracts people who recognise that they are in need in some way and have the need to change. They may not have previously found help or sought help from other sources.

In the past Christ Church has taken referrals from social services. It had two Kent County Council (KCC) funded placements for supported care located in family homes. However, funding was withdrawn following budget cuts at KCC social services.

Newcomers are not expected to take part in Sunday service rotas for about six months so that they can take time to adjust and orientate themselves to the culture of Christ Church through participating in activities (Williams, S. B. 2002: p.38). It is expected that every member has a therapeutic pastoral role to play with newcomers (Holmes 2004: p.219).

It can typically take a newcomer six months to commit to joining Christ Church. The process takes time as the newcomer begins to understand the commitment that is necessary to starting a journey of personal positive change. This is a process that occurs through listening to other people's stories and receiving teaching on the principles of the discipleship journey. Some newcomers decide to leave before committing to join. Williams (2002: p.42) identified that long-term membership was dependent on a commitment to the discipleship journey

alongside the faith dimension. She found that commitment was an emotional as well as a cognitive decision.

Whenever members leave it is acknowledged corporately and can be used to celebrate the member's time at Christ Church and support them in their future. Usually the person or persons leaving will make the announcement during the Sunday morning service.

1.6.11 Peer Review Process

The community participates in an annual Peer Review from the Community of Communities Project (Haigh 2002). This project is a joint initiative from the Royal College of Psychiatrists Centre for Quality Improvement and The Consortium for Therapeutic Communities (TCTC). The community completes a detailed Peer Review Report that is based on the core values of a therapeutic community. A Peer Review team reviews the report and then visits the community. This team all come from other therapeutic communities and comprise of a Lead reviewer, typically someone who is experienced in the field of therapeutic communities through being a member of one, and two or three other team members.

The first Peer Reviews tended towards using clinical and structural terminology which made the process difficult for the Christ Church members to understand. This is because Christ Church did not fit into the typical definition of a therapeutic community based on a residential treatment unit. The community is in the eighth year of this review process and considers it as part of the normal yearly review. The research conducted by Holmes and Williams as well as the ongoing Peer Review process has engendered a community that is now accustomed to asking questions about itself and thinking through strategies and solutions to problems that arise.

1.6.12 Christ Church Therapeutic Faith Community

In many ways Christ Church resembles the Geel community models in its family orientated approach. It can also be described as an alternative community (Kennard & Roberts 1983: p.85) in the sense that the community welcomes the disaffected that is to say those that have not been able to find a home in the traditional church environment and may not have been helped by traditional

mental health services. But the community is not 'anti-psychiatry' as Christ Church works with the local mental health and General Practioner services. However, it does not use diagnostic labelling and it attempts to 'normalise' the condition of mental illness in order to eliminate stigma.

The community does not have a hierarchy of professionally trained staff treating clients or residents. The community operates on an 'expert by experience' basis. Although it applies the 'quintessence' of core values (Haigh 1999), Christ Church differs from other therapeutic communities because it does not treat, does not have a inclusion or exclusion criteria and has no limit on the length of stay. This means that there is no anxiety around treatment termination and having to leave the community. In this way Christ Church resembles a traditional church where the length of stay varies for each individual or family.

There are two main differences between Christ Church and other therapeutic communities. Firstly, Christ Church teaches a way of life through life-long learning about self and others. It is not just about recovering from mental or emotional illness, it is recovering the whole person to live in terms of personal positive change. This is alternatively termed 'well-being', 'flourishing' or 'resilience', where the emphasis is changed from addressing the negative issue of mental illness and choosing to focus on the positive areas of generating well-being and recovery (Ruini et al. 2003; Fava & Tomba 2009). Secondly, it is a church which meets on Sundays it is a public place of worship. It offers on-going membership with a focus on religious belief and the 'discipleship journey' contributing to a personal sense of meaning that helps to develop the self-concept.

Summary
Christ Church is a registered therapeutic community that practices the 'core values' but differs from other therapeutic communities in many ways. Many of these differences relate to its being a church and to the *Rapha* discipleship model of wholeness.

In the next section some of the pertinent literature on religion, spirituality and mental health will be presented in order to demonstrate the current understanding of this subject with regards to health and well-being.

1.7 The Researcher

I began work as a hospital pharmacist 25 years ago when the mentally ill were treated within Victorian Institutions. At this time medication was limited and was sedative. Psychological therapies were not widely developed or used.

In 2002 my family and I joined Christ Church from a *Rapha* Group in Sussex. Both my husband and me had been benefiting from the teaching in the *Rapha* weekend workshops and from local *Rapha* discipleship groups, but felt the desire to become part of the Christ Church community.

I began work as a specialist mental health pharmacist in 2003 for the Kent and Medway Partnership Trust. As part of my continuing professional development I received a professional qualification in the Certificate in Psychotherapeutics in 2004. This is a course that teaches psychopharmacology, pathology, diagnostics and about other mental health treatments. Over the last 20 years there has been de-institutionalisation with the closure of the big asylums replaced with a greater emphasis on care in the community. There is now a greater choice of pharmacotherapy that enables improved patients overall daily functioning but with different side-effects. I encountered patients who described the benefits of newer atypical antipsychotics that allowed them to 'feel' and to function. There were also complaints from those whose medication caused 'emotional blunting'. However, for some patients the experience 'emotional blunting' was a relief from overwhelming emotional distress. More recently there has been a greater emphasis on psychological therapies, early intervention, patient-centered care, crisis resolution teams and primary care teams who operate as gatekeepers to the secondary care facilities. Some patients desire the safety of being 'locked-up', whereas others are afraid and angry in being detained. Financial crisis in the mental health services means that alternative solutions to hospitalisation have been sought for people in mental and emotional distress.

My professional occupation provided a contrast to Christ Church in the different approaches taken towards recovery from mental illness. This was especially highlighted in cases of posttraumatic stress disorder (PTSD) that I came across within the Trust and the trauma related disorder encountered in Christ Church. This interested me from the perspective of learning about emotional issues underlying mental illness. This led to personal research in the field of traumatic

stress that I discovered was a relatively new field of research focusing on emotional disorder that had similarities to the *Rapha* model of emotional healing. PTSD research encompasses genetic, biological, emotional, psychological, and social vulnerabilities and conducts research generating holistic paths to posttraumatic growth and resilience. I was a member of a workshop team that spent time teaching *Rapha* workshops in Rwanda where trauma is a national issue. The combination of developments in psychopharmacology, community based care, PTSD and the *Rapha* model developed my interest in emotional healing and well-being.

Within Christ Church I was a member of the Leadership Team for three years and continued to be a part of the Ladies' Pastoral Team and Risk Management Team. These positions within Christ Church combined with the length of time I had been involved with Christ Church and *Rapha* meant that I am perceived as a more experienced member. These roles within Christ Church have given me experience in dealing with mental health issues within the community setting and in Mental Health Services, the two sometimes overlapping.

My interests lie in seeking to understand the needs of those who are mentally and emotionally ill and how those needs can be best met. The mental health services are able to offer a service that is limited by budget and policy decisions and Christ Church can offer a service that is limited by voluntary support. The two services have often supported each other. My interest is in discovering more about the experiences of members of Christ Church with regard to their 'discipleship journeys' and how they perceive that Christ Church has been positive and negative for them. As Christ Church is both a church and a therapeutic community it can offer long-term membership, social structure, and spiritual and religious dimensions that are not available to the mental health services. I am interested in what part religion and spirituality played in attracting people to join.

Interdisciplinary approach

I concluded that my approach to the study needed to be interdisciplinary in order to be able to encompass the breadth of research into a therapeutic community. The reason for this is that Christ Church is a therapeutic faith community, which can be explored in terms of social and psychological theories but also includes spiritual, philosophical and ethical issues.

The Oxford English Dictionary defines multidisciplinary as 'involving several academic disciplines or professional specializations' and interdisciplinary is defined as 'relating to more than one branch of knowledge' (*Compact Oxford English Dictionary for Students* 2006). I have used the term interdisciplinary in order to distinguish it from the term multidisciplinary that is used in the health services meaning the team approach to treating and supporting patients.

The main focus of this research is on the newcomers who have typically found themselves on the margins of society for many and various reasons. They have not found the help that they wanted or needed in the existing institutions such as health services or churches. In ways they have found themselves socially excluded. This study adopts a similar approach to Bonner (2006) in his examination of the causes and possible solutions to social exclusion where he argues that 'social exclusion is a highly complex phenomenon that involves a wide range of complex needs'. For Bonner (2006: p.xix) this necessitated the use of a multidisciplinary approach in addressing the biopsychosocial issue.

The complexity of these issues has been addressed philosophically in relation to critical realism (Bhaskar & Danermark 2006). The philosophical stance of critical realism allows for and welcomes the interdisciplinary approach in recognising that there are multiple levels of reality that need to be researched by different methods, by different researchers (Danermark 2002).

If this same interdisciplinary model is applied within the mental health services then it becomes important to involve all professionals in addressing patient needs. Since 2003 there has been an initiative aimed at multidisciplinary ways of working the results of which were reported by the National Institute for Mental Health in England (NIMHE) and the National Workforce Programme called 'New ways of working' (2007). One of the ten essential shared capabilities was to work collaboratively to achieve the best possible care and outcome for patients (National Institute for Mental Health in England & Sainsbury Centre for Mental Health 2004: p.3). When all the professions are used and involve carers and third sector agencies as well as the patient a more holistic approach can be reached, which also includes addressing the spirituality. It is my contention that to remain

closed off to research and development in other fields hinders advancement in mental health.

Summary

In this chapter the concept of therapeutic community has been introduced. The difficulty in defining therapeutic community has been demonstrated. Christ Church therapeutic faith community had been introduced along with the previous research carried out in this context. A comparison between Christ church and other types of therapeutic community was presented. In the next chapter the background literature to the study is presented.

2 Background Literature

In this section some of the literature is presented on spirituality, religion and health. The literature is extensive and has identified the complexities involved in attempting to study religion and spirituality. This section will present an overview that provides a background to the current study.

2.1 Religion and Spirituality in Mental Health

In this section the terminology used in the thesis will be presented with a review of the literature on religion, spirituality and health. The literature is extensive and due to the limitations of time and space in this study the key points pertinent to the context of Christ Church as a Christian church and faith community will be addressed.

2.1.1 Defining Faith, Religion and Spirituality

There is an extensive literature that seeks to clarify the definition and meaning of the terms religion, faith and spirituality (McGrath 1999; Zinnbauer, Pargament & Scott 1999; Hill, Peter C et al. 2000; Cook, C. C. H. 2004; Sims & Cook 2009). William James (1902) defined personal religion:

> 'as the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine'.

In a review of articles concerning 'religion' and 'spirituality' from 1960 to 2000, the authors found a decreasing number in articles relating to religion and an increasing number related to spirituality (Weaver et al. 2006). This reflects a changing emphasis away from organised religion to individualised spirituality.

Research has demonstrated that many people describe themselves as spiritual (Hill, Peter C et al. 2000; Cook, C. C. H. et al. 2012). In particular mental health professionals, 'New Agers' and college students were found to more likely call themselves spiritual and not religious (Zinnbauer, Pargament & Scott 1999). Research establishes that there has been a tendency to associate 'religion' with negativity and 'spirituality' with positivity such that the terms have become

polarised (Zinnbauer, Pargament & Scott 1999; Hill, Peter C et al. 2000; Sims & Cook 2009). There has been an emphasis on equating religion with the social and spirituality with the individualistic. Sims and Cook (2009: p.5) suggest that the term religion is associated with 'historic baggage'. A proposal is made that neither term should be considered as either positive or negative and both can retain the possibility to be valenced either way (Zinnbauer, Pargament & Scott 1999).

In a different approach to defining spirituality Vaillant (2008) proposes that it is defined by eight positive emotions, awe, love, trust, compassion, gratitude, forgiveness, joy and hope. His argument is that these emotions are the social emotions that make people less self-obsessed.

Both religion and spirituality have been defined as 'meaning-making'. Silberman (2005) defines religion as a 'meaning-making system'. Cook's (2004) descriptive study of literature on addiction and spirituality, identified core/force/soul, meaning/purpose, humanity as three of the 13 conceptual components. The concept that spirituality is a journey or growth and change is supported by the core themes of spirituality identified by Martsolf and Mickley (1998) as, meaning, value, transcendence, connecting and becoming. A definition of spirituality that embraces both the personal and the social is that of Cook (2004: pp.548-9):

> 'Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationships with that which is intimately 'inner', immanent and personal, within self and others, and/or as relationships with that which is wholly 'other', transcendent and beyond self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values'.

2.1.2 Pathogenic Religion

Religion has been described as pathogenic which is harm or sickness generating (Clinebell 1984; Seeber, Park & Kimble 2001). In research on positive and negative religious coping patterns positive religious coping were found to be associated with a view of a benevolent God, forgiveness, spiritual connection and spiritually supportive interpersonal relationships (Pargament et al. 1998). Negative

religious coping was associated with the view of a God who punishes and is powerless, interpersonal discontent and spiritual discontent. Negative religious coping was associated with poorer mental health outcomes such as, greater emotional distress, poor quality of life, psychological symptoms and callousness towards others. Religious belief and practice can become part of internal defences that resist self-knowledge (Martin, D. 1968: p.183), which leads to lack of inner security resulting from guilt and shame from having to hide doubts. Pattison (2000: p.252) identifies some aspects of religion that are harmful such as the problem with the self in Christian tradition as having to be denied or 'dying to self' and a tendency to engender and promote shame as a means of control (*ibid*: p.229). Koenig, McCullough and Larson (2001: pp.227-8) identified negative effects of religion that included excessive ritual behaviour and devotion, but also negative effects such as legalistic behaviour, concealing of illness and disorder. 'Religious struggles' are associated with anxiety related pathologies, such as depression, paranoid ideation, obsessive-compulsive disorder and somatization (McConnell et al. 2006). This association is most strong in those individuals who have had a recent illness or injury.

The church, which can be a place of hope for the individual in times of need, can also become a place of shame when dogma and belief transcends the individual's need for love and acceptance (Martin, D. 1968: pp.183-84). As Aronson (2000: p.9) suggests posting the Ten Commandments in the classroom is not a way to teach young people how to be empathic towards to each other.

2.1.3 Salugenic Religion

Religion has been described as salugenic which is health or wholeness generating (Clinebell 1984; Seeber, Park & Kimble 2001) and salutary (Sun et al. 2012). Positive and negative effects of religion have been described in detail and on mental health (Koenig, McCullough & Larson 2001). Health benefits are noted to come from meaning-making (George, Ellison & Larson 2002; Emmons 2005; Silberman 2005), social support (George, Ellison & Larson 2002; Barnett & Johnson 2011). Health benefits have been noted in HIV/AIDS (Ironson et al. 2011), cardiac patients (Ai 2004) and in mental health (Tepper et al. 2001; Shaw, Joseph & Linley 2005; Green & Elliott 2010; Sun et al. 2012). Although a national survey did not find any difference between the prevalence of common mental

disorders between people who were religious and those who were not (King et al. 2006).

2.1.4 Church Belonging

Putnam (2000: p.74) proposes that belonging to a group or organisation is not enough and draws the distinction between just belonging and participating. Writing about religious participation and social capital, Putnam suggests that American religious behaviour is becoming more individualised without the benefits of strong supportive attachments. However, Roof (1996) proposes that privatised religion may not be the whole answer and postulates that for the sociology of religion the methods used to research current trends have not yet been able to deliver data on 'religious capital'. What is needed is further research on how individualised religion may inspire believers but not 'belongers' (Putnam 2000: p.74). In other work conducted in this field Day (2009) discovered that amongst young people believing and belonging were interconnected. Belonging may not have involved formalised religion or church attendance or even meta-narratives, but they had beliefs and these beliefs were formed relationally.

'Religiosity gap'

A grounded theory study (Magaldi-Dopman, Park-Taylor & Ponterotto 2011) was conducted into how psychotherapists view spirituality and religion that demonstrated significant conflict within and between the therapist and client. This was a result of personal conflict within the psychotherapist about their own personal journey of faith and/or also a conflict between the therapist views and the client views. The study suggested that discussion about the therapist's personal spirituality and religion was not encouraged whilst training and therefore therapists lacked the skills needed to reduce this conflict and the negative impact on clients.

In psychiatry a study examining a potential 'religiosity gap' between psychiatrists and their patients found that where a gap existed this may result in a asymmetrical power relationship that can undermine the patient's faith (Cook, C. 2009). In discussing the evidence for an effective therapeutic relationship Norcross (2011b) proposes that the therapists religious or spiritual framework is an important contributor to therapeutic alliance. The result of this was a recommendation that therapists could state their religious or spiritual position to potential clients.

Psychotherapy recognises the need to understand clients religious and spiritual frameworks (Norcross & Wampold 2011b), to the point where it is recommended that therapists advertise their own religious and spiritual position (Norcross & Wampold 2011a; Worthington et al. 2011). There is evidence that Christians will choose a Christian therapist (Walker et al. 2011), and where there was congruence between a therapist and client's religious and spiritual beliefs there were closer therapeutic relationships and beneficial outcomes (Post & Wade 2009). Swinton builds on these core concepts and suggests that within mental health professionals need to be able to address these issues with patients and clients (2001: p.25). This leads on to examining the literature on the importance of relationships and social support in mental health.

2.2 Therapeutic Relationships

The importance of therapeutic relationships in mental health has been well documented. In this section a review of the literature on the core components of a therapeutic alliance and therapeutic relationships is presented.

2.2.1 Dyadic Relationships

Therapeutic community is described by Kennard as having,

> 'an impulse to focus on the quality of relationships and communication between people, on the way they naturally set about dealing with one another, as the essential working material of treatment' (1983: p.vii).

In the first chapter of Denis Martin's (1968: p.16) book *Adventure in Psychiatry* he suggests that mental illness always expresses itself in disturbed human relationships and the greatest therapeutic treatment that can be offered is to help people understand this and develop new ways of relating. He also goes on to say that relationships that are accepting and understanding of others are the core characteristics, for the church (Martin, D. 1968: p.184) and define therapeutic relationships as more than technique, but as

> 'a capacity to accept people as they are….with understanding and a sustained desire to help over very long periods of time. The emotionally and mentally sick

especially need this kind of acceptance to provide the security within which they can seek solutions to the problems of themselves' (*ibid* p.148).

Within psychotherapy the importance of the relationship between therapist and client has always been recognised. There are those who have sought to define the relationship in therapeutic terms (Bachelor & Horvath 2000; Gelso, C. 2009), and others who have sought to identify the core characteristics (Rogers 1957; Norcross & Wampold 2011a), and their importance on outcomes (Horvath & Symonds 1991; Brown, J., Dreis & Nace 2000). This research has produced important findings such the role of empathy and congruence between therapist and client.

2.2.2 Rogers' Therapeutic Conditions

Carl Rogers (1961) summarised the factors involved in good outcomes from therapy that still form the basis of the therapeutic relationship or therapeutic alliance. He proposed that there were five conditions of learning in psychotherapy. The first condition was that of the client 'facing a problem' (*ibid*: p.282) that is to say the client is aware that they have a need which they have been unable to cope with. The second condition is 'congruence' by which he meant that the therapist is 'genuine, 'without front' or façade, openly being the feelings and attitudes which at that moment are flowing in him' (*ibid*: p.61). As an example Rogers illustrates this by situations in which a person is aware of another person who is being disingenuous and this leads to lack of trust. The third condition is 'unconditional positive regard' demonstrated by warmth, positive and acceptant attitude toward the client (*ibid*: p.62). The fourth condition is that of empathic understanding that he describes as the therapist senses the feelings and personal meanings of the client (*ibid*: p62). The fifth condition is that the client should be able to perceive or experience the therapist's congruence, empathy and acceptance (*ibid*: p.284).

Congruence

Rogers (*ibid*: p.339) defined the concept of congruence as a term used to indicate the accurate matching of experience, awareness and communication. He provides an illustration of congruence as an infant that is hungry and at that moment is integrated and unified in his whole being with hunger and communicating that hunger. This is contrasted with an illustration of a man who becomes angry in a

meeting but when confronted with his anger denies it. The degree of incongruence is unknown to the man. Rogers proposes an existential choice for therapists:

> 'to communicate one's full awareness of the relevant experience is a risk in interpersonal relationships. It seems to me that it is the taking or not taking of this risk which determines whether a given relationship becomes more and more mutually therapeutic or whether it leads in a disintegrative direction' (ibid: p.345).

For Rogers (1961: p.63-4) the process of how a client moves to greater congruence is through the client being listened to. The client then becomes able to listen to himself through having the therapist reflect acceptance and unconditional positive regard.

Congruence is defined in psychotherapy as being wholly integrated in the relationship along with positive regard, empathy and genuiness. Congruence can be seen as a personal characteristic (intrapersonal) of the psychotherapist as well as a mutual, experiential quality of the relationship (interpersonal) (Kolden et al. 2011). This definition includes qualities such as empathy and genuiness. According to the Task Force on Evidence-based Relationships, there is some evidence to suggest that congruence or genuineness is an effective component in psychotherapy, but this requires more research (Norcross & Wampold 2011a).

2.2.3 Listening

The importance of listening within psychiatry has been described as 'intensified listening' (Williams, R. 2005), listening with ears, eyes and heart (Shooter 2005), and 'active listening' (Rogers, C. R. & Farson 1987). Goleman (2006: p.255) identifies that one constraint for health professionals is time, where having the time to listen deeply is not always available. The importance of listening is included in models of rapport where mutual attentiveness is described as an essential component (Tickle-Degnen & Rosenthal 1990) and is part of forming a 'therapeutic alliance' (Norcross 2011). It is identified in a therapeutic relationship where effective listening is combined with empathy and understanding allowing the patient to express concerns, permit discussion and to negotiate (Kai & Crosland 2001). It is also described as part of empathy, which is another key component in 'therapeutic alliance' (Watson 2007; Singer & Lamm 2009; Bohart, Watson & Greenberg 2011). One important aspect of listening is that it can result in learning.

Learning can distinguish the therapeutic community process from the medical model where the patient can be a passive recipient of treatment.

> 'where the resident is in a position of a learner, who benefits most when he is interacting with the material to be learned. In this case the material includes the other people in the community and the individuals own thoughts and feelings' (Kennard & Roberts 1983: p.12).

All these examples of listening include cognitive, emotional and non-verbal listening. This was an important finding in Susan Williams' (2007: p.57) doctoral research where 'prejudicial judging' was a cause of the 'trapped self' being unable to change. Relationships that are 'accepting' are not compatible with pre-conceptions about another person. This is a finding that Odis Simmons (1994) made regarding the use of psychological tests, treatment plans and diagnostic criteria that reduce therapeutic constructs to that which is familiar to the therapist.

2.2.4 Equality, Mutuality and Power Balance

David Kennard (1983: p.8) contrasts democratic style in therapeutic communities with the traditional medical model of making people uniform and manageable or the need to look after people in a protective but controlling way. One aspect of positive relationship is the equality that is a basic principle in therapeutic communities (Kennard & Roberts 1983: pp.12-3). Equality is seen as human and psychological. Human equality may be defined as, 'we should treat others in the way we would like to be treated'. Psychological equality is defined as having no division between 'sick' and 'well'. This theme was identified by Rapoport (1960: pp.270-1) who observed 'untrained' and 'natural' persons who were valued in forming relationships with patients where the goal was to eliminate bureaucratic hierarchies, replacing 'bad' relationships with 'ordinary', 'good' ones.

Mutuality has been discussed within the field of learning disabilities where carers are aware of the inequality in power but attempt to overcome it through treating people as human beings not objects of care (Cushing 2003). In mental health the importance of power and trust and choice have also been discussed as important factors in establishing and maintaining therapeutic relationships (Laugharne, Richard & Priebe 2006; Laugharne, R. et al. 2011).

2.2.5 Peer Support

An example of a positive experience in a psychiatric hospital was found in a qualitative study of perspectives of enduring mental ill health. The value of mutual patient support was identified as a positive characteristic of these services illustrated by data suggesting that the patients had helped as much as the staff (Kai & Crosland 2001).

2.2.6 Social Support

Social factors play a key role in either creating vulnerability or resilience. The research conducted by George Brown and Tirril Harris in Social Origins of Depression (1978) was able to identify key social factors, such as class, social support including the intimacy relationships as at least correlational to the development of depression in women. In *Bowling Alone* Robert Putnam (2000) suggests that there may be a link between social isolation and ill health. He suggests 'Where once we could fall back on social capital – families, churches, friends - these no longer are strong enough to cushion our fall' (*ibid* p.335).

Marriage, friends and family support were protective factors predicting a reduction in mortality (Berkman & Syme 1979) and the lack of emotional support after myocardial infarction predicted an increased risk of death (Berkman, Leo-Summers & Horwitz 1992). Social support is found to be a buffer against stress and the vulnerability to the common cold (Cohen & Wills 1985; Cohen, Tyrrell & Smith 1991).

Other research conducted in this area has been in the field of post-traumatic stress disorder (PTSD) where the concept of resilience is considered the key to understanding why only some develop PTSD. Resilience has been defined as adapting well in the face of adversity and 'the ability to bounce back from negative experience, or even significant adversity, by flexible adaptation to the ever-changing demands of life' (Yehuda, R. 2006: p.380). Some of this research has focused on areas of social support (Wong, M. R. & Cook 1992; Charuvastra & Cloitre 2008; Cloitre et al. 2008), social attachment and emotion regulation (Côté, Gyurak & Levenson 2010). Other areas of resilience research also indicate the importance of social relationships (Siegel 2001; Davis, Luecken & Lemery-Chalfant 2009; Fava & Tomba 2009; Nuttman-Shwartz & Dekel 2009; Zautra

2009) and demonstrate the relationship with psychological well-being (Brown, G. W. et al. 1986; Steptoe, Dockray & Wardle 2009).

In other fields loneliness (Cacioppo, Fowler & Christakis 2009; Cacioppo & Hawkley 2009), the need to belong (Baumeister & Leary 1995), belongingness (DeWall, Baumeister & Vohs 2008) and sense of community (Chavis & Pretty 1999) were all important factors in establishing resilience and in recovering from mental illness.

Belonging can be seen as the antidote to social exclusion, which has been identified as a cause of stress and ill-health (Putnam 2000: pp.326-35; Department of Health 2011). Putnam (2000) focuses on the sociology of social connectedness as a basic need and as a source of personal and social well-being. Cacioppo and Patrick (2008) relate findings from cognitive neuroscience to other interdisciplinary fields to establish basis for their theory about loneliness and the human need for social connection. Each author draws on neurobiological research to propose that humans are social beings who have an innate drive to be socially connected to other human beings. Belonging may also militate against continuous threat or adversity (Nuttman-Shwartz & Dekel 2009). Scheff (1975a) proposes a social model of personal change:

> 'What is needed are ways of creating change that deal with individuals in social settings rather than in isolation. The key ingredient for such a procedure appears to be communication that allows for emotional release, on the one hand, and for the creation of a group in which there is strong social solidarity and which will help sustain the changes on the other' (Scheff 1975b: p.85).

For a Christian, shame in combination with doubt may arise as a result of the church's emphasis on belief that does not address the real mental and emotional experiences of an individual.

> 'the individual with conflicts involving a sense of failure, guilt, and hopelessness cannot feel truly accepted and understood in such an atmosphere and this is one of the reasons he may turn to a psychiatrist' (Martin, D. 1968: p.184).

This concept of isolation is linked to the literature on social exclusion that is another term for describing isolation. Social exclusion was identified in qualitative research on enduring mental ill health as a key concern (Kai & Crosland 2001). The study showed that victimisation, isolation and poverty combined intensified fear and led to hopelessness and low self-worth.

The roots of social exclusion

The findings of research into the antecedents of homelessness have shown that childhood adversity is significantly associated with homelessness and also with a higher rate of suicide (Bonner & Luscombe 2008; Shelton et al. 2009). In particular a high correlation was found between childhood separation or exit from home or a father in prison (Shelton et al. 2009) and breakdown in significant relationships has also been identified as a key factor contributing to homelessness (Bonner & Luscombe 2008: p.57). In addition there has also been evidence to suggest that social inequality has a role in increasing vulnerability to illness (Putnam 2000; Wilkinson & Pickett 2010) as well as health inequalities (Forbes & Wainwright 2001; House, J. S. 2002).The attitudes of society towards mental illness are regularly measured (Office of National Statistics 2010) as stigmatisation and fear of stigmatisation (Corrigan 2004; Baumann 2007; Sajatovic & Jenkins 2007; Schulze 2007; Thornicroft et al. 2007; Corry 2008) have a profound effect on those with mental illness. It has been suggested that mental health professionals can stigmatise their clients as the research found there was no difference between the negative attitudes found in the general population and those found in mental health professionals (Nordt, Rossler & Lauber 2005; Lauber et al. 2006). Being prescribed an anti-psychotic can also result in stigma for the patient (Sajatovic & Jenkins 2007). Social exclusion which results from the above can be as painful as physical pain (Kross et al. 2011) and have a profound impact on individuals and society (Bonner 2006).

The most popularly read research on this subject was Erving Goffman's analyses in *Asylums* and *Stigma*. The use of the terms 'discredited' and 'normals' illustrated the dehumanising potential of stigma (1961, 1963). A ground-breaking study was conducted by Helen Lewis (1971) by observing clinical interviews where she identified 'low visibility' shame that went undetected in nearly every interview. This suggests that shame is a very common emotion that can be easily missed because it results in concealing and hiding.

Despite some references to pathogenic religion, for those with extensive emotional and psychological damage the church has been and is a place of support (Martin, D. 1968; Kennard & Roberts 1983; Goldstein & Godemont 2003). Following on from the proposal that Christ Church provides a way to facilitate the development of self, in the next section the literature on the self will be presented in order to provide a concept of self as used in this thesis.

2.3 Defining Self

The Self was defined by William James in 1890 (1999) as both the 'I' and 'me', where the self is both 'I' as the subject and 'me' as the object of my thinking. James described the me-self in three categories, 'material me', 'spiritual me' and 'social me', this notion would have been alien to those in the 16th century where an individual self was not recognised (Baumeister 1986: p.36) (*ibid* p36). Cooley (1902: p.152) proposed that our self-concept is made from the viewpoint of others, the 'looking glass' self. In this proposal the self is constructed from how we perceive others react to us and therefore is a social self. Mead (1934) also proposed that the self is dualistic in terms of a subjective 'me' and an objective 'I'. He proposed that the formation of the objective 'I' is through social interaction. In this respect Mead and Cooley share the similar theory that there is a duality of self that is socially constructed. However, Michael Lewis (1992: p.45) argues that the objective self cannot be constructed solely by social interaction and proposes a genetic predisposition to developing the intellectual capacity to form objective self-awareness or 'me'. The development of objective self-awareness has been shown to occur alongside imager self-awareness and the verbal use of personal pronouns (*ibid*: pp.46-9). Baumeister's (1999: p.2) model also supports this by describing the self in three components, agentic, social and self-reflexive.

2.3.1 Self-Concept

In psychology self or self-concept can be defined as having three components, self-image, self-esteem and the ideal self (Gross 1992: p.607). Self-image is the way in which a person describes himself or herself. Self-esteem is evaluative of the extent to which a person likes, approves or feels how worthwhile they are. In other words how the self-image is evaluated can depend on how much the self-image differs from the ideal self. The ideal self is the kind of person they would like to be. The person may want to be different in some aspects or want to be a totally

43

different person. Another way in which people seek to define themselves is, through unique traits, in terms of dyadic relationships and in terms of group membership, otherwise called the 'individual, relational and collective self' (Sedikides & Brewer 2001).

2.3.2 Neuropsychological Development of Self

This avenue of research is generating interesting ideas on the nature of self through research of brain development in infants and children related to development of a sense of self. Research has been conducted in neurobiology, psychology, brain imaging and observational studies of infants and children. Studies of individuals with brain injuries and disease, and posttraumatic stress disorder (PTSD) have provided deeper insight into the way the brain functions and helped identify specific areas of the brain responsible for processing information ((Damasio 1994; LeDoux 1998; Schore, A. N. 2002, 2009a; van der Kolk 1994).

In an extensive study Tronick and Beegley (2011) present various research from infant parent dyadic relationships that point towards vulnerability in mental health. They suggest that various problems can arise in infants 'meaning making' which when repeated over long periods of time become dysfunctional and may lead to mental illness.

Although there is no one specific region of the brain dedicated to the self there is clearly a phenomenological sense of self (Decety & Chaminade 2003). The brain is split into left and right hemisphere with each hemisphere responsible for processing different information and having different memory systems (Schore, A. N. 2011). The current view of the left hemisphere is that it is responsible for logical, linguistic and praxis functions. The right brain processes experiential, emotional and corporeal information about the self (Devinsky 2000; Schore, A. N. 2009b). The right hemisphere matures more quickly than the left and is also more dominant which is thought to be because of the role of intersubjectivity in the developing brain (Schore, A. N. 2009b; Trevarthen 2009). Drawing on attachment theory, which proposes that the infant learns how to self-regulate emotions through first being regulated by the primary caregiver, the right hemisphere of the brain begins to develop and mature through the formation of emotional bonds which directly effect the neurobiological development. This suggests that the self is

co-constructed emotionally through the right brain primarily through the primary caregiver or attachment figure (Schore, J. R. & Schore 2008; Schore, A. N. 2009a). Positive attachment with a primary caregiver allows emotional regulation to be positively regulated by the caregiver. This co-regulation leads on to self-regulation leading to self-awareness. In situations of negative care giving, the child may not progress towards self-regulating his or her own emotions which can lead to impairment of personal identity and sense of self (Schore, A. N. 2002).

2.3.3 Unified Self

Both Damasio (2000) and LeDoux (1998) suggest that the self is perceived to be a unified whole by the way the brain's neural systems co-ordinate and organise information from the past and present. They both propose that the self is formed from both memory and current body, emotion and social context. The complexity of this task is performed at multiple levels in the brain involving both the unconscious and the conscious. Gilbert (2010: p.38) also supports this view and suggests that mental health problems occur when the organisation breaks down such as in trauma or overwhelming emotions. Gilbert's (2010: p.38) proposition is that the self is a complex mix of motives and cognitions (multi-mind) with the illusion of being a single self and that the function of the self is as an organiser of memories, emotions and beliefs into a cohesive sense of self. In Barresi's (1999) philosophical approach to becoming a person one of the ways in which he identifies the process occurring is through 'the unifying action of self-narrative'.

2.3.4 Duality of Self

A discussion on the duality of the self is presented by Michael Lewis (1992: p.42) in which he makes the useful distinction between objective and subjective self-awareness. Objective self-awareness is the act of turning attention towards the self in terms of what the self knows and regarding plans and desires. Subjective self-awareness is formed from systems and processes that know about the world but to which a person does not or cannot pay attention to. Lewis highlights the capacity of human beings to have knowledge about knowledge, which is a unique form of consciousness. The capacity of the self as 'I' to reflect on the self as 'me' is what Lewis describes as a duality. This duality can be traced through writings from James through Cooley and Mead to Lewis' work with infants and children. In essence the ability of the self to be self-aware is what Lewis suggests is in one

sense a duality of self. It is also this capacity that is the basis for the development of self-conscious emotions.

2.3.5 Spiritual Self

Stephen Pattison (2000: p.253) suggests that the self is not well defined in Christian tradition and therefore problematic as it is still considered necessary to 'deny the self' as a locus of sin. 'The self is in a permanent state of siege and temptation' (*ibid*: p.255). However, the spiritual component of the self has been discussed. The human spirit or soul has been addressed in the literature by Swinton (2001: p.14) suggests that it is 'the fundamental breath of life instilled into human beings and which animates them and brings them into life'. For Holmes it is the *imago Dei*, as a meaning behind human life and as embodied spiritual beings (2005: p.72). These concepts are reflected in Freud's original word *seelisch* as 'of the soul' that implies emotionality rather than Strachey's translation as 'mental' (Symington 1986: p.117). Damasio (1994: p.xxvi) states that 'feelings form the base of what humans have described for millennia as the human soul or spirit'. The inclusion of the spiritual is considered essential by Holmes (2005: pp.65ff) as a model for human make-up. In order to redress this he returns to a Hebrew concept of human make-up that includes the spiritual alongside the physical as 'an indivisible unity' for his model of personhood (*ibid* p.76).

Jourard (1971: p.80) suggested that, ''Spirit' has been a nagging and persistent problem to psychologists'. He proposed a humanist approach in his determination to explore the concept of 'spirit' in an attempt to bring fresh meaning to it. He suggests a link between what he terms low 'spirit titre' and mental illness (ibid p.80ff). In psychiatry, recognising the soul of a person in listening is considered important (Williams, R. 2005). The concept of spiritual intelligence is defined as the ultimate intelligence (Zohar & Marshall 2000), and the statement and eponymous book title, that patients are the *Heart and Soul of Change* by Hubble, Duncan and Miller (2000a). Using 'soul' or 'spirit' instead of mental and emotional conveys a sense of wholeness and a sense of the real, essential core of humanness (Holmes 2005). As Harré (1998: p.11) suggests for a Christian a sense of self includes a sense of being related to a supernatural being who is not embodied.

Taking these ideas a step further as true self or core self which Leary (2003) states 'is hard to conceptualise', can be defined as;

'the sum of a person's natural, uncontrived tendencies and inclinations as reflected in one's motives, values, feelings, self-perceptions, world view and other traits' (*ibid*: p.53).

Summary

Drawing on the literature presented in this section a concept of self develops emotionally, cognitively, socially, culturally and spiritually through connections within oneself and with others. In the next section the literature on emotion will be presented that helps to define emotion as used in this thesis.

2.4   Defining Emotion

Firstly the distinction between emotion, affect and feelings will be presented. Affect is the term used to describe any state that is not cognitive, such as hunger or fatigue. Feeling is the term used to describe the mental experience of an emotion but can be non-conscious (Damasio 2000: p.37). A feeling has to become conscious for the 'feeler' to 'know' that they are feeling (Lane 2006). Defining emotion however, is more complicated for reasons that will be presented next.

The literature on emotion has expanded rapidly over the last twenty years and yet there is still no universal definition of emotion. It would appear that not much progress has been made since Duffy's (1934) remark about emotion being a 'term of convenience'. In Cacioppo and Gardner's (1999) extensive review article on emotion they state 'emotion is a short label for a very broad category of experiential, behavioral, sociodevelopmental and biological phenomena'.

The lack of agreement about defining emotion can be demonstrated by a small survey of scientists researching the field of emotions who were unable to agree on either structure or function of emotion (Izard 2010). However there was moderate to high agreement for neural circuits and neurobiological processes involvement with emotion, that emotion is a phenomenal experience or feeling and emotion also includes perceptual-cognitive processes. The main conclusion of Izard's paper was that an operational definition of the term emotion must be given and

any discrete emotion being studied must be adequately labelled. With this in mind the current status of the theories and arguments regarding emotion will be presented in order to state the position on emotion adopted in the current study.

2.4.1 Theories of Emotion

Damasio (1994: p.126) suggests that emotion is a 'survival mechanism' that humans are born with and that this mechanism is added to by other strategies over the course of a person's development. Thus emotion is governed not only by biology but also by environment, which is an important framework for this thesis.

Emotion and Language

According to Michael Lewis (1992: p.20) the emotional life has three components, emotional states, expression and experience. Emotional state is defined as a specific internal bodily response to a discrete emotion (*ibid*: p.14) Emotional expression is the external manifestation of the internal state (*ibid*: p.20) and emotional experience is the person's evaluation and interpretation of the emotional state (*ibid*: p.27). Emotion is embedded in narrative structure (Widen & Russell 2010) and is therefore limited to language expression (Solomon 2002). This thesis is concerned with emotional experience as expressed through verbal language that conveys emotional states. Emotional experience depends on the cognitive processes of interpretation and evaluation. These cognitive processes include perception, memory and elaboration. Emotional experience therefore requires learning in order to label emotions and this is mainly achieved through socialisation (Lewis, M. 1992: p.28).

Basic emotions

Over the years there have been suggestions that there are basic emotions (otherwise called primary or fundamental), which we are born with and from which more complex (or secondary, self-conscious) emotions emerge. The number of basic emotions has been disputed from two, displeasure and pain, (Mowrer 1960) to an unlimited number. Kemper (1987) proposed that there are limitless number of emotions which are dependent on social recognition of situations. Typical examples of basic emotions are, anger, disgust, fear, joy, sadness and surprise. However, there is no consistency about which emotions are basic, it is proposed that some of the differences are due to inconsistency is terminology.

Theories of emotion are varied and tend towards grouping emotions into primary (otherwise called basic, low pathway) (LeDoux 1998: p.161) and secondary (complex, high pathway or self-conscious) emotions (Tangney 1990; Lewis, M. et al. 1989). They can also be categorised as positive (Fredrickson 2001) and negative emotions depending on whether they feel unpleasant or pleasant (Lazarus & Lazarus 1994). Lazarus and Lazarus (1994) also group emotions into empathic, existential, those formed from unfavourable life conditions (for example, relief, hope, sadness) and favourable life conditions (happiness, pride and love).

Ortony and Turner (1990) present an argument against a small set of basic emotions. The authors conclude that a single definition of basic emotion is not accepted and therefore confusion arises as a result. Against this argument is that all emotions are considered basic and not just a small subset (Ekman 2001: p.57).

Secondary or self-conscious emotions

Self-conscious, also known as secondary or complex, emotions have been defined as higher pathway. They are dependent upon cognition or self-conscious awareness. These emotions are proposed to develop later in childhood than basic emotions (Lewis, M. 1992; Schore, J. R. & Schore 2008). The family of self-conscious emotion is made up of jealousy, envy, empathy, embarrassment, shame, pride, hubris and guilt. There is more agreement about which emotions are self-conscious than which are basic (Lewis, M. 1992; Tracy & Robins 2004; Leary 2004).

Cognition and emotion

Dalgleish and Power (2001) suggest the Aristotelian view of cognition as a part of emotion now pre-dominates and that emotion is now no longer seen as dangerous and uncontrolled, in other words as irrational. Likewise cognition is no longer viewed solely as informational processing, conscious and rational (Damasio 1994). The approach that LeDoux (1998: p.69) adopts is to treat emotion and cognition separately for research purposes whilst recognising that they are interlinked. Lazarus (2001) states that to consider cognition, emotion and motivation separately implies that they exist and that this is in fact a 'fiction of scientific analysis' as in reality these three concepts are interrelated.

However as Izard discovered in his survey of emotion researchers there is no agreed definition of fear and no agreed definition of the number of emotions, basic or otherwise. Some researchers even propose that it is unhelpful to consider emotions as a separate entity from cognition as the two occur simultaneously (Lewis, M. D. 2005).

In a cognitive-motivational-relational theory of emotion, emotions are not separate from cognition and are constructed out of personal meaning (Lazarus & Lazarus 1994: p.5),

> 'Emotions are like no other psychosociobiological construct in that they express the intimate personal meaning of what is happening in our social lives and combine motivational, cognitive, adaptational and physiological processes into a single complex state that involves several levels of analysis' (Lazarus 1994: p.6).

Their theory supports the view that emotions are socially and relationally produced.

Sociological

In Solomon's paper entitled *Back to Basics (2002),* he presents a review of the literature on basic emotions and concludes that the issue is not neurological or phenomenological but 'emphatically social'. This is due to the significance of social and cultural differences in language and expression of emotion. Solomon (2002) proposes that all emotions are neurologically based but that the 'identity of each emotion lies elsewhere in their phenomenal structures'. Solomon goes on to propose that emotion is holistic and writes 'the problem with reductionism is that it tends to focus too avidly on the reduction and lose sight of what is reduced' (*ibid*: p.131). Lazarus (2001: p.14) concludes that the holistic view of emotions is the most natural however, reductionist analysis cannot be condemned as it is useful in providing some answers to questions about emotions.

2.4.2 Religion and Emotion

Research has emphasised the link between religion, spirituality and emotion (Hill, Peter C et al. 2000; Emmons & Paloutzian 2003). The emotional aspect in religious belief and experience has been well documented and reviewed. Silberman (2005) reviews this and finds that religion can influence emotion several

ways. For instance, through the emotional experience of closeness to God or Higher Being. Religion can influence emotion through teaching avoidance of certain emotion, for example, hate, and encouraging others, for example, joy. A third way in which emotion can be influence is through belief in a God who is either harsh and judgmental or all-loving and beneficent.

2.4.3 Emotional Contagion

'Emotional contagion is conceptualised as a multiply determined family of psychophysiological, behavioral and social phenomena' (Hatfield, Cacioppo & Rapson 1993: p.4). Shame in particular is recognised as a contagious emotion (Lewis, H. B. 1971: p.15) as well as fear (Rachman 1978: p.76). Neurobiology confirmed the concept of contagion with the discovery of mirror neurons (Gallese, Keysers & Rizzolatti 2004; Metzinger & Gallese 2003) which are primed to react to other peoples emotions so that we can experience them as if they were our own (Cacioppo & Patrick 2008: pp.155ff). This is not only an emotional response but a physical reaction such as a contagious smile (Goleman 2006: p.41), and described as the 'intersubjective contact' (Stern 2004: p.70). Interestingly, this system is not cognitively driven or appraised and therefore suggests that emotional contagion operates outside of conscious awareness, at least initially.

2.4.4 Emotion is Valenced

One way to distinguish between emotion and cognition is by adopting the proposition that emotion is valenced (Ortony & Turner 1990; Lerner & Keltner 2000; Russell 2003). The 'circumplex model' of affect proposes that emotion is based on linear combinations of two independent neurophysiological dimensions, valence and arousal (Colibazzi et al. 2010). This model is of interest because it proposes a continuum from pleasure to displeasure as the basis for all emotions with the possibility of endless variety of emotional experience depending on the independent variables. Including valence and arousal as components of emotions supports the view of emotions as having an evaluative component (Lewis, M. 1992).

2.4.5 Emotion and Connectivity

Emotion can be considered as communication but by using relational theories of emotion (Campos, Campos & Barrett 1989; Lazarus & Lazarus 1994) communication can be extended to connectivity. Emotion is important in social interactions and relationships, and is regulated and developed through interpersonal and social interaction. Connectivity can be considered to be a more useful term to help distinguish the function of emotion from cognition. Emotions mediate connectivity intrapersonally and extra-personally. This is borne out by neurobiological research in babies and infants relationships with primary caregivers (Schore, A. N. 1996; Schore, J. R. & Schore 2008; Trevarthen 2010). The emotional bonding between child and caregiver leads to right brain development and a sense of self. Healthy attachment leads to healthy emotional self-regulation and development of empathy. This is supported by Russell's (2003) psychological emotional model in which emotion is related to an intentional object for example, a person, a thing, an event.

Summary

To return then to Izard's discovery that there is no agreed definition the only way forward when writing about emotion is to use working definition and context. Emotions have a neurological basis, are phenomenal and perceptual-cognitive-motivational. Drawing on Michael Lewis' concept of an emotional life this thesis is also concerned with emotional experience as expressed through verbal language that conveys an emotional state. From the literature four ways have been identified in which emotion can be distinguished from cognition they are, emotion is contagious, expressed, valenced and relationally connective.

2.5 Theory of Incongruence and Congruence

The grounded theory of congruence that emerged in this thesis is conceptualised from two emergent processes of pathogenic emotion and relationships that lead to losing self conceptualised as incongruence and salugenic emotion and relationships that lead to finding self conceptualised as congruence. In both concepts the process begins externally to the self through relationships and environment that becomes internalised.

3 Quantitative Methodology

3.1 Introduction

In this chapter the aims of the study and the methodological considerations are presented.

3.2 Aims of the Study

The primary aim of this study was to establish if there were any health benefits from belonging to an open therapeutic faith community called Christ Church based in Kent. The research is a longitudinal, mixed methods study using outcome measures in the quantitative arm and in-depth interviews in the qualitative arm to explore newcomers experiences of joining Christ Church.

Primary aim

- The purpose of this study is to determine the health benefits of belonging to an open therapeutic community.

Secondary aims

- To determine who benefits from the community.
- What individual members perceive as important in the therapeutic community.
- The importance of social factors compared to therapeutic factors.
- Whether belief influences the perceived benefit to belonging to the community and what the belief is in?

3.3 Consideration of the Methodology

Methodology is a general approach to studying research topics whereas method is a specific research technique (Silverman 1993: p.470). Consideration of the methodology preceded selecting the method of data collection and data analysis.

The primary aim was to generate outcome data to evaluate whether or not the community was beneficial in terms of health and to demonstrate for whom the community might benefit. In addition importance was placed on obtaining the views and opinions of the newcomers about the community. Therefore the study was designed with these questions in mind. Choosing one single method would mean losing either outcome data or the participant's perspective. The goal was to

choose a methodology appropriate to the setting and the question (Haynes 1999). The methodology chosen to address both the primary and secondary aims is a mixed method approach.

This chapter presents the rationale for the choice of methods and demonstrates how methodological challenges were resolved through attending to the issues of ethics, validity, insider/outsider status and to the philosophical position of the thesis.

Developing a randomised controlled trial (RCT) for this community would have been challenging, as it is unusual as a therapeutic community and as a church. Various other quantitative methods were considered that included retrospective analysis, waiting list control, and a comparison with a therapeutic community day hospital for personality disorder. Another alternative was to use survival analysis. Each of these had shortcomings:

- Using retrospective analysis to measure the difference in participants' mental health before and after joining the community had significant limitations. Existing members are already integrated into the life and ethos of the community and may have difficulties remembering their previous mental health and details of how they felt joining the community.

- Waiting list control was not possible in an 'open' therapeutic community that is also a church. This is because the church on a Sunday is a place of public worship and as such not subject to operating a waiting list. Potential members do not go onto a waiting list, as there are no limits on placements. Many members will describe not actually committing to join the community until months after moving to it. They physically arrive and then spend time deciding on whether to commit. A complex psychosocial process takes place that is unique to each individual joining the community. Additionally it has been know in the past for people to move to Deal with the intention of joining Christ Church without warning.

- Comparison with a local National Health Service (NHS) therapeutic community day hospital providing treatment for personality disorders was deemed inappropriate as Christ Church is not specifically for personality

disorder. Christ Church also provides more support than a day hospital and does not have the structure of staff and patients that can be found in a NHS unit.

- Survival analysis could be carried out by measuring those participants who remain in the community, using Kaplan-Meier survival analysis (Altman et al. 2000: pp.281-283). However, the weakness is that moving away from the community is not necessarily a sign of failure; rather it can be a sign of good recovery.

Summary

Measuring outcomes to measure effectiveness along with qualitative inquiry provides the methods deemed suitable for researching these objectives.

3.4 Choosing Mixed Method Research

Introduction

It is suggested that mixed method research is based on a rejection of the dichotomy between qualitative and quantitative approaches (Tashakkori & Teddlie 2010). It is proposed that mixed method research closely parallels everyday human problem solving by answering questions concerning what happened, how and why. Mixed methods research (MMR) has been described as multi-methods, multi-strategy, mixed methods or mixed methodology (Bryman 2006). In this study the most common term, mixed methods research (MMR), will be used. The definition is derived from many existing definitions:

> 'Mixed methods research is the type of research in which a researcher or team of researchers combine elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration' (Johnson, R. B., Onwuegbuzie & Turner 2007: p.123).

The quantitative arm of this study derives from a positivist epistemology that argues for an objective researcher researching a question in the absence of context with the intention of discovering a truth or evidence. On the other hand the qualitative arm of the study is researched through immersion in the field and without claims for discovering truth. Instead, the current study adopts Sayer's

(2010, p. 69) concept of 'practical adequacy' as 'knowledge generates expectations about the world and about results of our actions which are actually realized'.

3.4.1 History of Mixed Methods Research

MMR was derived from triangulation which was introduced by Campbell and Fiske (1959). However, there are examples of published mixed method work before this date (Jahoda, Lazarsfeld & Zeisel 1972). Since then MMR has evolved into various types such as component research designs, integrated design, such as, iterative, nested and holistic designs (Caracelli & Greene 1997; Hanson et al. 2005). It is suggested that the chosen method should depend on the context, (Fielding 2010) and secondly a rationale must be stated for why mixed methods is better than a single approach (Bryman 2006).

3.4.2 Uptake of MMR

There are increasing numbers of MMR studies being performed in the health services (Chiesa, Drahorad & Longo 2000; Barr et al. 2010; Chow, Quine & Li 2010; Hodge et al. 2010; Arnold 2011; Baheiraei et al. 2011; Koekkoek et al. 2011). Specifically these are used in nursing (Al-Hamdan & Denis 2010) mental health nursing (Kettles, Creswell & Zhang 2011; Roberts & Bailey 2011), palliative care (Arnold 2011), trauma research (Creswell & Zhang 2009) and pharmacy (Guirguis 2011). The reasons given for conducting MMR in these studies were to reach a deeper understanding of the area under study and to gain more methodological rigour. The three of these studies will be discussed in more detail.

Chiesa, Drahorad and Longo (2000) adopted a concurrent explanatory design using standardised outcome measures and in-depth interviews conducted with treatment dropouts. This was designed to study early termination in treatment at a therapeutic community. Qualitative data were analysed using content analysis. The results of the study demonstrated difficulties with certain aspects of community life that required changing in order to reduce the number of early treatment terminations. This study achieved its aims using a mixed method approach.

Koekkoek et al (2011) used a sequential multi-methods explanatory design consisting of four different studies including grounded theory. Using an unusual secondary analysis of previous studies he developed an explanatory model of how patients were labeled as 'difficult'. However, a preconceived theoretical framework of Parsons' 'sick role' concept was used. Therefore the results only pertain to the extent to which the results confirm or deny this framework.

The studies conducted by Barr et al (2010) and Hodge et al (2010) describe a rationale similar to the current study. The researchers aim was to place an equal priority on recording the experiences of the participants as well as monitoring outcomes in order to triangulate the results. However, the results did not produce any conclusions as to why voicing negative experiences of the community could combine with improved outcome measures.

3.4.3 The Advantages and Disadvantages of Combining Methods

Using the definition of MMR given in section 3.3 (Johnson, R. B., Onwuegbuzie & Turner 2007) it is possible to see the advantages of combining different methods. The advantage of aiming for breadth and depth results in a study that transcends numerical argument. By including views and opinions of the participants, the main reasons for the numerical results could be elucidated.

As Sackett and Wennberg (1997) state the important point is not to perpetuate a division between the methodologies but to value each equally as necessary in obtaining a whole picture of the area under study. Choosing a methodology based upon strengths or weaknesses is not appropriate but rather what is the question and how is this best answered. In either case what needs to be demonstrated is reliability and validity.

However, the main disadvantage of combining methods is that the study becomes lengthened and the volume of data produced could be large so that the analysis may be 'thin' and compromised. In order to minimise the risk of a lengthy study generating a complex workload, the study can be designed so that the methods used compliment each other and enable concurrent data collection and analysis.

Summary

In summary there are advantages of breadth and depth of a mixed method study could outweigh the advantage of a single method. A concurrent design was chosen where the qualitative and quantitative data were collected concurrently and analysed together. However, the issue of combining philosophical positions needs addressing in order to determine whether combining methods is appropriate.

3.5   Ontology and Epistemology

Introduction

The next section will demonstrate how the philosophical position was addressed in the area of mixed methods studies.

3.5.1   Introduction to Critical Realism

A positivist view is linked with quantitative methodology and emphasises objectivity, measurement, generality and replication of research. In philosophical terms it means that what is 'knowable' is that which is measurable or observable. Positivism therefore leads to the development of instruments with which to measure or quantify. A weakness of positivism is that it cannot provide a foundation on which to research people's own experiences and meanings that include spirituality and religion. Critical realism was selected to be able to encompass both the qualitative and quantitative parts of the study which will be introduced here and further discussed in section 4.7.6.

Critical Realism is a relatively recent philosophical position developed primarily by Bhaskar (1978). There are four particular areas relevant to this study and the considerations of the researcher within this study, which are;

- stratified reality
- intransitive and transitive objects
- structure and agency
- complexity

Stratified reality

In critical realism Bhaskar (1978: p.13) suggests that there is a stratified reality comprising of three levels, the first is called 'real', the second is 'actual' and the third is 'empirical'. Equality is given to the scientific and non-scientific, the objective

and subjective ways of understanding the world. An example of this stratification is given by Danermark (2002) with the following levels;

- Social and cultural levels
- Psychological levels
- Biological levels
- Molecular levels

Each of these levels has equal importance but requires a different methodological approach.

Intransitive and transitive objects

The theory of knowledge in critical realism is based upon the intransitive and transitive objects of knowledge. The intransitive knowledge of objects is independent of human activity and can exist without us knowing of them, for example, gravity and light. The transitive objects of knowledge is the already existing knowledge base, for example, theories, paradigms and methods. These are created by man and therefore means that transitive knowledge is socially dependent (Bhaskar 1978: p.21).

Structure and Agency

Critical realism argues the equal importance of both structure and agency by suggesting that there is a world independent of the mind but that this world can be changed and influenced by human activity. This differs from interpretivism that emphasises agency and positivism that emphasises structure. The capacity of human beings for self-change or making our own history is noted by Sayer (1999: p.19) which supports the stance of critical realism.

Complexity

The critical realist view is that there is no simple cause and effect. Everything is a complex interplay. Social reality has many layers and we can only hope to view some of the layers (Danermark 2002).

But critical realism rejects the relativism and the 'methodological anarchy' of Feyerabend (1975), who suggested that scientists do not need to pay attention to philosophical argument. Critical realism rejects the view that science is the highest

form of knowledge and allows for different forms of knowledge to be equally important (Sayer 2010: p.20).

Critical realism argues for 'adequacy of ideas' rather than truth. In doing so it enables a bigger broader picture on human experience in society to emerge (Pilgrim & Bentall 1999; Bergin, Wells & Owen 2010; Wand, White & Patching 2010).

3.5.2 Valuing Quantitative and Qualitative Research Equally

A critical realist approach to knowledge states that there is no hierarchy of knowledge. Both methodologies have strengths and weaknesses, but these are contextual. Each methodology is strengthened by being used to research the appropriate question in the right setting.

Whereas quantitative methodology claims statistical significance, qualitative methodology claims significance in its 'relevance' and importance to the area under study (Morse 2004). However, if we are treating both methodologies equally then claims of one side over the other become irrelevant. Instead there is the need to adopt the view that each different level of reality will have its own relevant method (Danermark 2002).

Attending to the philosophical position first allows the reader to understand how critical realism has underpinned almost every aspect of this study.

3.5.3 Mixed Method Research and Philosophical Positions

MMR has drawn criticism from some as being epistemologically incompatible (Blaikie 1991; Denzin 2009). In not attending to the epistemological position of the researcher the whole basis of MMR can be undermined. For example, a researcher holding an interpretivist position may not be able to equally value the quantitative part of a mixed methods study and vice versa. It is interesting to note that none of the papers quoted in section 3.3.2 using MMR attend to the subject of epistemology perhaps assuming a positivist or empiricist approach rather than overtly stating it. The inattention to philosophical and theoretic elements in research is an issue that has been identified by Lipscomb (2008).

Johnson, Onwuegbuzie and Turner (2007) suggest that philosophical differences in mixed method research should be further researched but in the mean time a blending of epistemology is acceptable. Dattilio, Edwards and Fishman (2010) also suggest that epistemologies can be synthesised in order to overcome weakness inherent in both quantitative and qualitative methodologies. Both papers argue for proceeding with mixed method research despite epistemological differences between the methodologies used. However, Tashakorrie and Teddlie (2010) espouse the idea that it is not only methods that can be complementary, but the epistemology as well.

3.5.4 A Unifying Position

The approach taken in this thesis is to go beyond arguing for complementary epistemologies and search for a framework that encompasses both arms of the mixed method research. The critical realist position can provide this framework in total without needing to resort to combined philosophical stances.

3.5.5 Critical Realism and Mixed Method Research

Critical realism is an ontology and epistemology that fits with this mixed method design and with the perspectives of the participants. MMR is recognised as an important 'third research paradigm' between the positivist and metaphysical positions. Critical realism has been called the third way or middle way in philosophy of the natural sciences between empiricism and positivism on the one hand and relativism on the other. The critical realist position allows the researcher to transcend the boundaries of disciplines whilst remaining systematic and analytic in approach.

3.6 Summary

Critical realism is a philosophical position that allows for knowledge to be more than is measurable and more than what is understood or experienced. It allows for equality of both positions and the possibility that in gaining understanding we can change things. Selecting the critical realist ontology provides a framework for conducting a mixed method research. In section 4.7.6 critical realism is discussed with reference to the qualitative methodology.

3.7   Usage of Outcome Measures

In this section the choice of outcome measures will be presented including examples of how previous research utilised the measures. From the literature presented in chapter one several outcome measures were identified from studies of therapeutic communities measuring psychiatric and general health assessments (Chiesa, Drahorad & Longo 2000; Chiesa & Fonagy 2000; Wright & Woo 2000; Crockford, Brunton & Surgenor 2003; Karterud et al. 2003; Pedersen & Karterud 2004; Orlando et al. 2006; Kelle 2007; Chiesa et al. 2009).

These papers used outcomes that were based on quantitative measures using various rating scales including specific psychiatric rating scales as well as quality of life measures. All of these studies included demographic data. Recognising that there may be newcomers to the community who would have no mental health diagnosis, the mental health assessments needed to be broad and 'normed' on the general population not solely on in-patient psychiatric cases. These measures would be used every six months over a two-year period to measure change in these scores. In addition a way of collecting demographic data was devised.

3.8   Psychiatric and Health Rating Measures

Psychiatric and general health rating measures can either be interviewer/observer rated or self-report. Observer rated measures are limited to observations about behaviour or verbal reports, for example, the Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham 1962). Self-report rating scales are designed to collect data from the 'phenomenal self', they are concerned with the experiences of the respondent (Derogatis 1994: p.2). The disadvantage of self-report scales has been suggested in psychoanalysis and social psychology as the limitations of the respondent to fully understand their limits of conscious self-knowledge and degree of self-deception (Nisbett & DeCamp Wilson 1977; Westen 1999). However, there have been attempts to address two particular issues with regard to self-report measures which are 'social desirability' and self-deception. 'Social desirability' is the response of either 'faking good' (declaring that things are better than they are) or 'faking bad' (declaring things to be worse than they are) (Barker, Pistrang & Elliott 2002: p.116). Some self-report rating scales can be administered by either the interviewer or by the respondent. The advantage of interviewer-administered measures is in being able to obtain complete reports with reasons why questions

are not answered. The interviewer therefore retains a degree of control in the process. However, control could also be a disadvantage where it could be seen as 'forcing' responses. Self-administered self-report outcome measures were chosen to distance the researcher from asking the questions so allowing the participants more control in the process. The time interval between completing outcome measures can influence the data, called 'test-retest validity'. For example, a short gap between repeating the measures can distort the responses because the participant is able to remember their previous responses. It is recommended that at the least a three month interval is optimum (Kline 2000: p.9). Although Derogatis (1994: p.7) states that with the Symptom Checklist 90 items-revised (SCL-90-R), there does not appear to be any test-retest reliability issues and therefore no bias in repeated administrations. Derogatis (*ibid*: p.6) has also proposed that the administrator of the SCL-90-R must believe in the validity of the measures.

A diagnostic interview was included in the study design in order to give a demographic profile of the mental health of individuals that join the community.

3.8.1 Mini International Neuropsychiatric Interview (M.I.N.I.)

In order to provide data for case mix on the newcomers attracted to the community a diagnostic interview was chosen. The Mini International Neuropsychiatric Inventory (M.I.N.I.) plus version 5.0 (Lecrubier et al. 1997; Sheehan et al. 1997; Amorim et al. 1998) (see Appendix I) was chosen as the diagnostic tool as this is an abbreviated structured interview compared with the longer Structured Clinical interview for DSM-IV (SCID-IV). This interview provides data on past and current psychiatric disorder for Axis I disorders and suicidality. This tool has been used extensively in research (Stearns et al. 2003; Dahlin & Runeson 2007) and practice (Black et al. 2004; Jones, J. E. et al. 2005).

This interview has been designed and developed by psychiatrists and clinicians in Europe and the USA to work alongside Diagnostic and Statistical manual (DSM-IV) and International Classification of Diseases (ICD-10). It is designed for use by psychiatrists, clinicians and non-clinicians. The disclaimer on pages 3-4 (see Appendix 1) note that the M.I.N.I. is not intended to be used 'in place of a full medical and psychiatric examination'; it is a 'tool to facilitate accurate data

collection'. The M.I.N.I. takes around one and a half to two hours to complete. It is based on decision tree logic. The M.I.N.I. plus version 5.0 interview has since been superseded by the M.I.N.I. version 6.0.

The researcher received diagnostic training through a professional qualification and working as a clinical mental health pharmacist. Professor Hale, who is one of the study supervisor's and a Consultant Psychiatrist, provided systematic and specific training on diagnostics and the use of the M.I.N.I. As the researcher was not diagnosing with a view to treatment it was agreed that the participants should view any diagnoses from the M.I.N.I. as being solely for research purposes. If the participants had not previously received a diagnosis for a mental health issue then advice was given to discuss the results with their general practioner if they had any concerns.

3.8.2 Primary Outcome Measure

Clinical Global Impressions Scale (CGI)
The primary rating scale chosen is the Clinical Global Impressions (CGI) scale (see Appendix II). This is an observer rated scale. It has two measures of one item, severity and improvement. The items are rated on a seven-point scale. The assessment is made by an experienced clinician with familiarity in the condition under study and is based on the available information to determine global functioning (Busner & Targum 2007). The single item of improvement is made in comparison to the previous rating. It is completed after a consultation or interview. In recent papers (Leucht et al. 2006; Kadouri, Corruble & Falissard 2007) the CGI (Guy 1976), performs very well against the British Psychiatric Rating Scale (BPRS) (Overall & Gorham 1962) and Positive and Negative Symptoms of Schizophrenia (PANSS) (Kay, Fiszbein & Opler 1987) for monitoring changes in health. It has had significant clinical usage.

3.8.3 Secondary Outcome Measures

World Health Organization Disability Assessment Scale –II- 36 item (WHODAS-II)
One of the secondary measures chosen was the World Health Organization Disability Assessment Scale-36 item (WHODAS-II) (2001) (see Appendix III). It assesses a broad range of domains including health, mental health, physical

health, drug and alcohol addictions and social functioning. This is suitable for the assumed broad case-mix of the community. The WHODAS-II-36 item has been shown to be sensitive in the detection of changes in patients with social phobia (Perini, Slade & Andrews 2006) and performed well in general practice (Bushnell et al. 2004). It has also been used to assess disability with regard to long-term psychotic disorders (Chopra, Couper & Herrman 2004). Using the self-administered 36-item scale takes around 20 minutes to complete. The WHODAS 2.0 has since superseded the WHODAS-II.

Symptom Checklist 90 items- revised (SCL-90-R)

The third outcome measure chosen was the Symptom Checklist 90 Items Revised (SCL-90-R) (Derogatis, Rickels & Rock 1976; Derogatis & Cleary 1977; Pearson Assessments 2012) (see Appendix IV). It is a 'measure of current point-in-time psychological symptom status' (Derogatis 1994: p.5). It is a self-assessment scale and is estimated to take around 12-15 minutes to complete and each item is a five-point scale. It was chosen because it was a short duration, multiple symptomology, self–report and self-administered. In addition it was important that this rating scale was normalised on a non-psychiatric population as well as a psychiatric one. This was because it was likely that not all recruiting participants had received previous treatment for a mental illness. Psychometric properties have been determined from over 1,000 studies and show that properties were weakest for detecting psychosis and strongest for measures of distress (Groth-Marnat 2009: p.523). This measure was designed with basic non-medical words (Derogatis 1994: p.5). Therefore it is acceptable for use in non-medical environments. This measure was used in a study of a therapeutic community for adults with posttraumatic stress disorder (PTSD) (Wright & Woo 2000) and also in a study of day hospital treatment for personality disorder (Karterud et al. 2003; Pedersen & Karterud 2004, 2007; Rossberg et al. 2010).

The 90-item scale was used for its diagnostic scope and breadth and avoided having to use different diagnosis specific measures. The shorter scales would not have afforded this breadth. This aspect was important in an unknown and potentially broad case mix.

3.9 Newcomers Questionnaire

Demographic data were collected to describe and contextualise the participants in the study in the form of a newcomers questionnaire (see Appendix V) asking several types of questions that may lead to 'sensitising concepts'. Sensitising concepts give you initial ideas to pursue and sensitise you to ask particular kinds of questions about your topic (Charmaz 2006: p.16).

The questionnaire was designed using a combination of rating scales and open questions. The rating scales were based on a five-point scale. Using five points is a balance between increasing reliability with increasing the number of points and having too few points that result in unreliable reporting (Garner 1960; Dawis 1987). Each scale point was 'anchored' (labelled) to provide clarity of meaning for the respondents (Barker, Pistrang & Elliott 2002: p.113). The open questions included asking for information, for example, about the newcomers' experiences of the joining process and their thoughts on the meaning of spirituality. The questionnaire also asked for information regarding accommodation, education, medical history and employment. These questions were designed to give a picture of what kind of person is attracted to the community. In total there were 42 different questions. The questionnaire was piloted on some existing members of the community who gave useful feedback and changes were made accordingly.

3.10 Study Sample

The sample chosen were newcomers to Christ Church. Newcomers are defined as people who had begun attending the church either by moving to Deal or by regular attendance at meetings within the previous six months. Regular attendance is defined as attending planned meetings, such as relevant group meeting and Sunday morning service, more often than not. Newcomers are in transition from pre-community life to beginning to attend the community towards joining the community, a process that can take months. The distinction between attending and joining has been observed over the years. Many people have started to attend Christ Church and either leave or make a commitment to join over an extended period of time. This transition phase might offer a rich source of data. However, if the participants had a slow transition into the community, this might affect the results of the outcome measures (Barker, Pistrang & Elliott 2002: p.113).

3.10.1 Inclusion Criteria

All adult newcomers to Christ Church within the last six months who were able to consent to participate could be included. The capacity to consent would be assessed from the presentation of the individual's mental and emotional state from their ability to understand and retain the information about the study.

3.10.2 Exclusion Criteria

Any person under the age of 18 and those unable to consent to participate were excluded from the study.

3.10.3 Demographic Data

The demographic data from the questionnaire are presented here

Table 3.1: Sample Demographic Data

Characteristics	N=9	%
Female	8	89
Male	1	11
Mean age (SD)	40 (1.36)	
Marital Status		
- Never married	6	66
- Married or cohabiting	2	22
- Divorced or separated	1	11
Ethnicity		
- White	9	100
- Black		
- Mixed race		
- Asian		
Education		
- Degree level qualification	4	49
- Level 3 diploma	2	22
- No qualifications	1	11
Employment		
- Full time	2	22
- Part time	2	22

- Unemployed	1	11
Benefits		
- Income support	2	22
- Incapacity benefit	2	22
Current psychotropic drug treatment	2	22
Living arrangements		
- Home owner with husband	1	11
- Rented with own family	3	33
- Sharing with another family	2	22
- Sharing with other singles	3	33
Previous admission to mental hospital	3	33
Previous treatment for mental health issues	6	66
Smoker	1	11
Addictions		
- Alcohol	2	22
- Food	1	11
Previous contact with community via		
- Workshops	7	78
- Members of community	9	100

3.10.4 Gender Demographics

Demographic data show that the majority of recruits to this study were female with a mean age of 40 (SD±1.36). This reflects the age range in the general membership of the therapeutic community. However, the ratio between male and female in the study is not reflected in the overall membership of the community. As calculated in November 2011, the percentage male and female is 62% female and 38% male and has remained at this level for at least two years.

3.11 Ethical Considerations

Ethical principles underpin all professional and research activity. Demonstrating an ethical approach to the human research is required by the University Ethics Committee and is mandatory training for mental health professionals. The researcher conducted the research according to the implicit and explicit social and moral rules of Christ Church.

The use of consultation was designed to provide an ethical foundation. The basis for this is a critical realist perspective that presupposes the therapeutic community will have its own ethics for treating other people humanely (Sayer 2000: p.180). These ethics may be the same or similar to attempts at 'normative thinking', for example, the Principles of Health Care Ethics, but they may also transcend them. It is particularly important that the participant's spiritual dimension is respected ethically (Dein 2004), which is an area that critical realism can accommodate.

3.11.1 Healthcare Ethics

As a basis for considering the ethics of this study the principles of biomedical ethics as originally developed by Beauchamp and Childress in 1979 and included in the Principles of Health Care Ethics (Beauchamp 2007), were adopted. The four overarching principles that overlap in certain areas are;

- respect for autonomy
- nonmaleficence
- beneficence
- justice

Each of these will be discussed in turn with the way in which they were applied in the current study.

Respect for autonomy

Respect for autonomy is the principle of personal self-governance. The importance of recognising a person's right to make their own decisions without interference or coercion, provided that they possess the capacity to reason and think through their choices (Beauchamp 2007: p.4). One outworking of this principle is through assessing participants for their capacity to consent and asking for consent whilst making it clear that they retain the choice to leave the study whenever they choose.

Application

The researcher's position on the Women's' pastoral team and risk management team in the community was not to be construed as an authoritarian position to coerce new members to participate. Instead mutuality in relationships as a key principle of therapeutic community life is stressed over any leadership role. Autonomy of the individual is paramount.

Included under this heading is the idea of personal choice regarding faith and religion. This is an important aspect for the community, which although based on faith principles does not coerce or evangelise non-faith members due to the vulnerability of the individuals who join the community. This would be seen as abusive behaviour.

Nonmaleficence – 'above all do no harm'

The main principle encompassed by nonmaleficence is doing no harm to the participants. Harm in research may occur through the use of novel or non-normal treatments or behaviours. Examples of this can be found in pharmacological research where side-effects and adverse events may occur during Phase III trials on human subjects. Harm may be defined as psychological as well as physical.

Application

Psychological harm was of concern because Christ Church does not use medical/pathological language and avoids using diagnostic labels and members are not monitored using outcome measures. No previous research using these types of tools had been performed before. Therefore the researcher was concerned about the effects of using a diagnostic interview and outcome measures on members of the community. On this issue the existing community members were consulted to obtain their opinions and encouraged this part of the study to proceed. Follow-up conversations were conducted with the participants after the baseline interviews. Given the regularity with which the researcher was in contact with the participants follow-up tended to occur quite naturally.

Beneficence

Beneficence encompasses a group of principles requiring prevention of harm, to provide benefits and balancing benefits against risk and cost. Consultation took place in order to discuss how to balance risk: benefit. This included the discussion of what the impact of a negative result would have on the community as well as the impact of using a diagnostic interview and other assessments on individuals. Any perceived overall benefit for the community should not outweigh any harm to the individual participant.

Application

The use of a diagnostic interview may result in identifying someone with a previously undisclosed risk of self-harm or suicide. The community has a clear self-harm policy that all members are expected to abide by. Members are expected to disclose to another member feelings of self-harm or suicide. If the study assessments identified someone with an undisclosed risk then the Risk Management team would need to be informed.

Another area of risk identified was the potential to inadvertently cause distress to the participants through the diagnostic interview or use of the outcome measures. In order to minimise the risk the researcher would follow-up all participants personally to check on the impact.

Justice

This is a group of principles that requires appropriate distribution of benefits, risks and costs. This overlaps with the above principles of beneficence in that justice includes impartiality, treating everyone as equally important and significant.

Application

There were no financial costs or inducements with this study. In many ways distributing the benefit and risks and minimising harm, was a key reason for the consultation and involvement of existing members. The principles of relationships in Christ Church are mutuality, non-hierarchy and equality. Therefore the goal was to demonstrate impartiality to all members of the community whether they were participants or not.

3.11.2 Process of Ethical Consent

Consultation

The researcher's aim was to do no harm to the community members and especially potentially vulnerable new members. The Leadership Team and the Trustees were consulted for permission to conduct the study (see Appendix VI) and to give them an opportunity to ask questions or express opinions about the study design. The existing membership was consulted on aspects of the method design to check for appropriateness, use and value for the community. This included piloting the questionnaire and the outcome measures on some existing members.

The consultation process resulted in alterations to the questionnaire but no alterations in the proposed outcome measures. The feedback from the pilot process was positive.   The choice of self-administered over interviewer administered outcome measures was a decision to increase control of the participant and decrease control of researcher in process.

At this point Ethical Consent application was made to and approved by the Kent Institute of Medicine and Health Sciences (KIMHS) Research and Ethics Advisory Group for the study into the health benefits of living in an open therapeutic community (see appendix VII). The application is for a mixed methods, two-year prospective study using outcome measures, CGI, SCL-90-R, WHODAS-II, plus the M.I.N.I. diagnostic interview to collect data on caseness, a questionnaire and in-depth qualitative interviews to be analysed ethnographically.

Summary

The key in developing the ethical approach of this study was to respect and incorporate the ethics of the community as well as the ethical principals developed by Beauchamp and Childress. The principles do not contradict each other but can be seen as complimentary. A consultation process was undertaken to obtain the views of the current membership regarding the overall study design and design of the newcomers questionnaire.

3.12 Recruitment Strategy

3.12.1 Flow Diagram of Recruitment Process

```
┌─────────────────────────────────────────────┐
│       Link established with Community Office  │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│     Individuals joining are referred by       │
│              Office to researcher             │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│         Capacity to consent assessment        │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│      All eligible participants provided with  │
│             an information sheet               │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│           Written informed consent            │
└─────────────────────────────────────────────┘
                      │
                      ▼
┌─────────────────────────────────────────────┐
│             Baseline Assessments              │
└─────────────────────────────────────────────┘
```
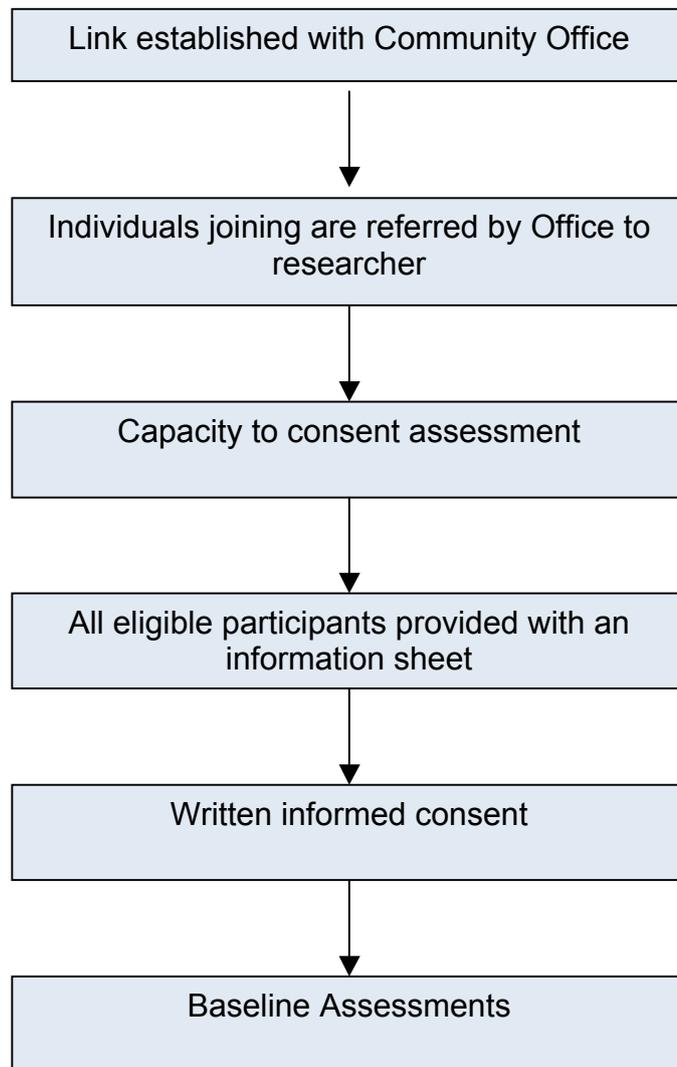
Participants were recruited through initial contact by the church office who informed the researcher. Each newcomer was informed about the nature of the research, including the intention to conduct a diagnostic interview and further in-depth interviews. Each newcomer was informed that the diagnostic interview was for research purposes only and was not to be seen as the same as receiving a diagnosis from a doctor. Time commitment was explained for example, the diagnostic interview would be a one and a half hour interview and further in-depth interviews would take around one hour each.

3.12.2 Statistical Power Calculation

The Kent Institute of Medical and Health Sciences (KIMHS) statistician performed a power calculation. The CGI was chosen as the primary outcome measure in order to assess how many participants would need to be recruited to achieve statistical significance.

Assuming a normal distribution curve and measuring a change in half a standard deviation with a two sided significance test of 0.05 significance level and a power of 80%, then with a correlation of 0.75-0.9 the numbers needed are between 12-28 subjects. From previous research, (Williams, S. B. 2002: p.98) this would take between six to twelve months. Dropout rates were difficult to calculate, as there have been many individuals who come to Christ Church stay for a period of time, leave and then re-attend at a later date. Follow-up interviews were conducted on those participants who dropped out.

The quality and type of data generated from the baseline and six-month assessment would be reviewed and further statistics could be applied at this stage to assess the power of the study.

3.12.3 Participant Information

All potential recruits were provided with an information sheet (see Appendix VIII) and description of the involvement in the research. This included the amount of time required for each assessment, what kind of questions they might be asked and an explanation the purpose of this research. Potential recruits were given up to three weeks to make a decision on whether to participate.

3.12.4 Consent and Capacity

All newcomers during this time period were assessed as having capacity to consent. Each potential recruit was required to take some time to consider his or her involvement before making a decision on whether to participate in the study.

Those that agreed to participate gave written and informed consent to the study (see Appendix IX). All participants were reassured about confidentiality that included safe storage of hard data and how coding strategy would protect names by the use of codes. This included anonymising the electronic data throughout the

study. No personal identifying material would be used in the thesis, which includes the use of employment details.

A flow diagram of the study is presented on the following page.

3.13 Flow Diagram of Study Design

```
          ┌─────────────────────────────────┐
          │   Recruitment of Newcomers to   │
          │      Therapeutic Community      │
          └─────────────────────────────────┘
                          │
                          ▼
          ┌─────────────────────────────────┐
          │  Baseline Assessment and Diagnosis │
          └─────────────────────────────────┘
                          │
Phase I                   ▼
          ┌─────────────────────────────────┐
          │        6 month Assessment       │
          └─────────────────────────────────┘
                          │
                          ▼
Phase II    Continuation or Re-Design
                          │
                          ▼
          ┌─────────────────────────────────┐
          │        1 year Assessment        │
          └─────────────────────────────────┘
                          │
                          ▼
          ┌─────────────────────────────────┐
          │       18 month Assessment       │
          └─────────────────────────────────┘
                          │
                          ▼
          ┌─────────────────────────────────┐
          │        2 year Assessment        │
          └─────────────────────────────────┘


Phase III              Off-Study Follow up
```
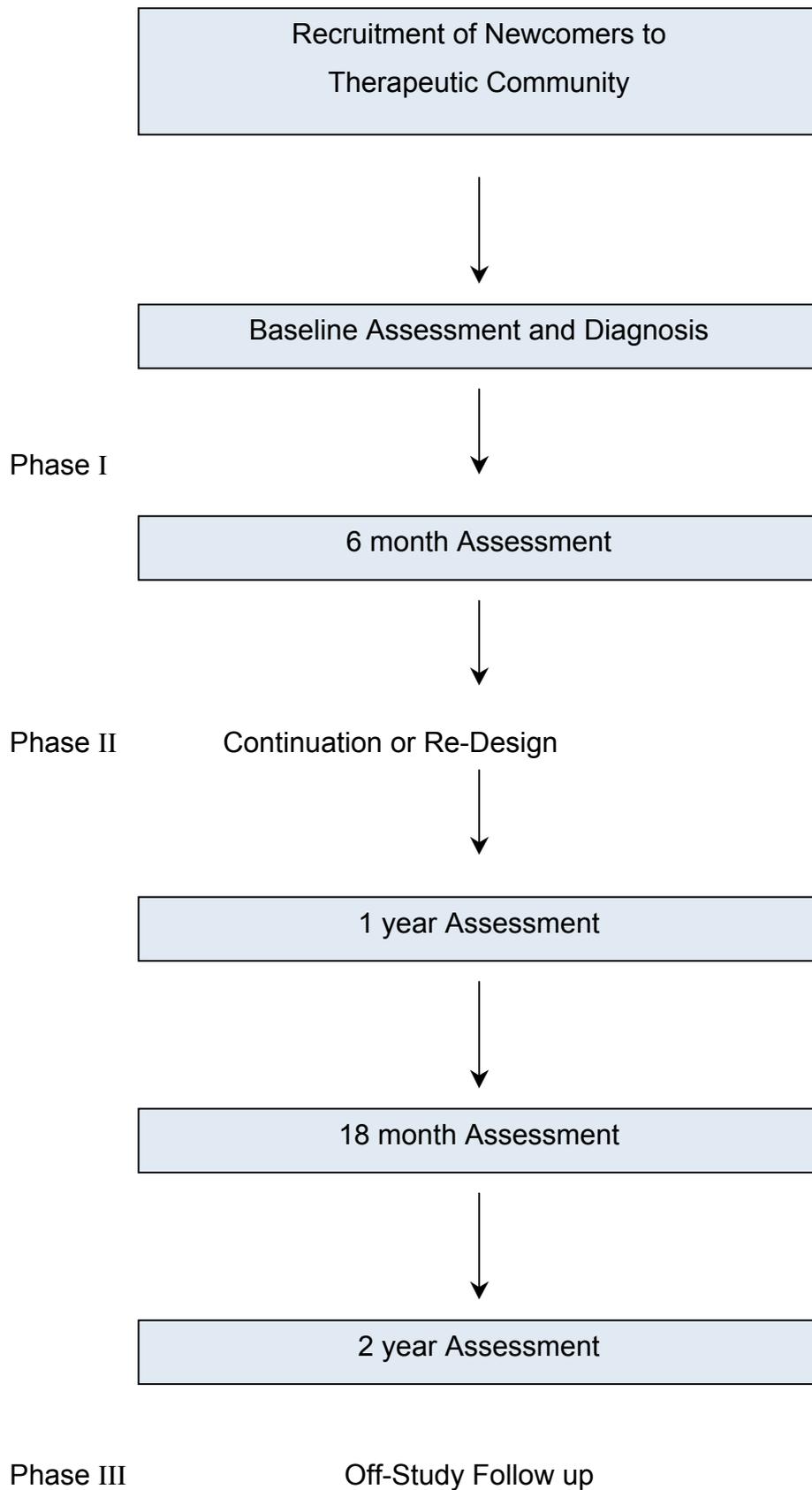
3.14 Phase One Data Collection

3.14.1 Baseline Assessments

The baseline assessments were conducted in a location of the participants' choosing. The reason for using the M.I.N.I. diagnostic interview and the type of questions were again explained. An explanation was given of the nature of the diagnostic interview for research purposes and not for treatment. The researcher explained that any questions or feedback from this interview would be discussed with them and the suggestion was made that any further questions or anxiety could be also discussed with their general practioner. After conducting the M.I.N.I. interview the participants were given a copy of the SCL-90-R to complete, followed by the WHODAS-II. The outcome measures were completed in the researcher's presence and enabled them to be able to ask questions that arose whilst completing the forms. At the same time the researcher completed the CGI measure.

At this interview a copy of the newcomers questionnaire was supplied for participants to take home allowing two weeks to complete. At the end of the interviews each participant was de-briefed on their experience and invited to telephone the researcher in the following days if they had any concerns or worries about the interview or about the whole research process.

Outcome measure data were collected at baseline and at six months for the quantitative measurements at which point the study was reviewed before proceeding with phase two. The qualitative interviews took place after six months.

3.15 Reliability, Bias and Validity

A definition of validity is the extent to which any interpretations and actions based on the test are justified (Chen, Donaldson & Mark 2011). Reliability refers to how consistent a set of measurements is and can be also called generalisability. The need to demonstrate reliability and validity in research is a core principle.

3.15.1 Validity

Validity can be used as the accuracy of the inferences or as a property of the method/research design. It has also been suggested that validity can refer to an

approximate truth of an inference. However, this is a definition that is at odds with a philosophical argument of what is truth and whether 'truth' ever be claimed. Therefore it is not the definition used in this study. Instead Chen, Donaldson and Mark's (2011) definition is used that suggests the researcher has responsibility to demonstrate how particular sets of inferences were arrived at using a particular method. In this case it highlights the importance of transparency in the research process.

One goal of quantitative research is to prove mathematical significance usually achieved using statistics. Underlying this is reliability and validity of the instruments used in measuring the area under study. The choice of instrument, the number of participants and the length of study are therefore important indictors of the quality of the study.

Within quantitative methods this included the need to identify validity in outcome measures. This was achieved through conducting a literature review on the outcome measures with regards to intrinsic properties of the tools themselves and the contexts in which they had previously been used. Outcome measures are tested for reliability and validity in different settings with different populations and different administrators. In choosing outcome measures it is therefore important to research the published papers designed to produce this evidence. Data from the M.I.N.I. diagnostic interview and outcome measures were presented to the study supervisor for discussion and debriefing. The aim of this was to establish internal validity in the use and interpretation of these data.

Participant motivation threats that include the participant perceptions of the situation cannot be identified prior to the study (Shadish, Cook & Campbell 2001). These threats will emerge during the study and may need addressing throughout the study period. This threat in particular became relevant to the design and analysis of the study.

3.15.2 Controlling Bias

There were two types of bias in particular that were addressed. Firstly conflict of interest and secondly the 'Hawthorne effect'.

The researcher's position as a member of Christ Church presents a potential conflict of interest. Regarding conflict of interest House (2011) reviewed many papers that could be described as rigorous in their design but still biased. The main problem he identified was that conflicts of interest were not overtly described in the research papers. This can be addressed through transparency of the researcher declaring conflicts of interest. The aim of the researcher was to approach the baseline assessments and interviews as a neutral observer researcher and not as either a mental health professional or a member of Christ Church. This will be made explicit in the section below one the researcher and also discussed in section 4.7 concerning insider/outsider positions in research.

Fetterman (1998) suggests that biases have a positive and negative function. The positive happens when biases are controlled for and therefore focus and limit the research effort. The negative is when uncontrolled biases affect the quality of the research. Within critical realism Sayer (2010: pp.45-84) argues against the idea of a 'value-free' approach to research and suggests that concept-laden or a theory-laden approach is more realistic concluding that the researchers awareness of bias can be a strength.

Where bias results in a false positive it is termed the 'Hawthorn Effect' derived from a study at the Chicago Hawthorn plant where an increase in worker productivity was attributed to a direct result of being researched. Steven Levitt and John List (2009) reevaluated the original research and subsequently concluded that the 'Hawthorne effect' had slight or negligible effects. However, the term is still in usage to describe any researcher induced short-lived improvement.

The argument is thus, that in conducting this research the participants may have perceived a benefit through additional contact with the researcher as a more experienced member of Christ Church. Whilst not directly therapeutic in nature as the researcher was not administering a treatment or conducting therapy, it could be seen as therapeutic time through adopting the Christ Church proposal that all relationships have the potential to be therapeutic. However, with this in mind this was not used as an inducement to participate.

3.15.3 Reliability

The reliability of this study depended on being able to demonstrate that the study had validity and therefore if it were possible to repeat this in another community with similar values with consistency. However, because of the unusual nature of the community the goal was not to demonstrate reliability in the sense of replicability unless the key components of the community emerged in order for replication to occur.

The unique position of the researcher in the community and the attending difficulties in how the participants perceived this would make replicability very difficult. The goal therefore is to demonstrate the outcome measures were in themselves reliable and that they had been used as they were designed to be used. In addition there is transparency in the process so that limitations and findings from the use of the methods are fully explained.

Summary

An important aspect of the ethical approach was to maintain transparency. A key to maintaining transparency was to clarify the position of insider/outsider stance of the researcher.

3.16 Consideration of Phase Two

At the end of phase one the study was reviewed to establish whether the chosen rating scales were sensitive to change in the light of the diagnostic interviews. There were four main concerns at this stage in the study that needed to be addressed before continuing with phase two. These were:

1. Low recruitment
2. Disclosure by participants of dissemblance in completing outcome measures and fear of the researcher
3. Main concerns of the participants contrasted with the main concerns from the consultation of existing members.

3.16.1 Low Recruitment

Low recruitment meant that there was no possibility for statistical significance from the data based on the power calculation. This combined with the other reasons

listed above led to reconsidering the value of continuing to collect the outcome data.

3.16.2 Disclosure

The disclosure by the participants of their fear of the researcher as a mental health professional and the consequences of dissembling in completing the outcome measures was a concern for the study validity. All participants were reassured that the researcher was not legally able to section them. The disclosure became the starting point for the subsequent in-depth interviews, which enabled them to explain their concerns about mental health professionals and their fears or experiences of mental health services.

3.16.3 Main Concerns of Newcomers

In applying ethical principles to the study a consultation was used to establish a basis for the research. The results of the consultation encouraged the research to be outcome focused. The existing Christ Church members were communicating a desire for the 'outside world' to 'hear their voice' and 'take them seriously'. However, it became apparent that their concerns were not the same as the concerns of the newcomers. The concerns of the newcomers were focused in on themselves as individuals and not outwards towards wider society.

3.16.4 Changing Analytic Framework

The disclosure of the participants led to a reevaluation of the qualitative arm of the study. Previously designed as an ethnography to determine specifically the benefits and non-benefits of belonging to the community, it now became a question of 'what was happening?' in order to determine why these behaviours had occurred. These kinds of questions could be studied using a theory generating approach that puts the participants' core concern as the focus.

The greater risk would have been to ignore the comments of the participants and to continue with the original data collection. In the manual for the SCL-90-R (1994: p.6), Derogatis states that the measure must not be administered by someone who does not believe in the validity of the clinical assessment process. However, he does not state the importance of the client believing in the clinical assessment.

The recruitment numbers were too low to be able to claim statistical power, but choosing to stop collecting the quantitative data could weaken the study. Continuing to collect outcome data may provide some results relevant to the overall conclusions in the study despite not reaching statistical significance.

3.17 Summary

This chapter has described the process of choosing the methodology and methods used in this thesis. The ethical basis for the study has also been presented. The choice to situate the study in critical realism enabled a mixed methods approach that encompasses both quantitative and qualitative methodology. This allows for the stratified levels of realities and enables the complementary view of epistemologies.

The chapter has presented the process of the study and shown the need to reflect on the findings from phase one. This resulted in a change to the analysis of the qualitative data from an interpretive to a theory generating method.

4 Qualitative Methodology

4.1 Introduction

Qualitative methodology allows the researcher to study questions relating to perceptions, opinions and feelings, that is to say the phenomenal and metaphysical aspects that positivist research does not usually address. Following a critical realist perspective this part of the study was of equal importance to the quantitative. In this chapter the qualitative methodology used and the methodological issues affecting the qualitative inquiry will be presented. A description of how the analysis was carried out, using examples from the current study, will also be presented.

4.2 Choice and Change of Analytic Framework

Using a concurrent mixed methods approach, the choice of qualitative method depended on the way the qualitative data were to be analysed. At the beginning of the research the qualitative arm was intended to be an ethnographic study of the social processes in Christ Church complimenting and triangulating with data from the quantitative arm.

Ethnography is often associated with anthropology and can be defined as the art and science of describing a group or a culture (Fetterman 1998: p.1). It was initially chosen to study the unusual nature of the community, especially its non-residential living. Ethnography aims to provide a 'rich' and 'thick' description of the community and its social processes. It is a flexible method using various approaches most commonly associated with participant observation, but also including interviews and document analysis. This study rejected the use of participant observation because of perceived difficulties in maintaining boundaries between the researcher and the participants. Collecting data from interviews and questionnaires allows boundaries to be developed.

Data analysis in ethnography is equally flexible applying both descriptive techniques for the context but can also includes explanations and theories (Atkinson & Hammersley 1998: p.183). Data analysis can include content analysis, rich description, thematic analysis and grounded theory (Fetterman 1998;

Charmaz 2006; Atkinson & Hammersley 1998). However, collecting large amounts of descriptive data to generate thick description is not the same analytic process as collecting data for generating theory and can lead to confusion. For an honest account of trying and failing to apply grounded theory in ethnography see Ingersoll and Ingersoll (1987).

Fay (1996: p.134) suggests that 'cause and meaning' need to be researched and conceptualised which requires outstripping the resources of those being studied. By this Fay meant that those under study may not be able to conceptualise their own meanings, the researcher does this on their behalf.

The participants' dissembling to the baseline assessments led the conclusion that the validity of the quantitative part of the study had been compromised and resulted in reconsideration of the study. Rather than proceeding with an ethnography looking for descriptive analysis of the data to triangulate or compliment the quantitative data, instead generating a theory of 'what was happening' was selected as a way forward. The same protocol was used and the same data collection method, but focus changed to grounded theory method to analyse the qualitative data.

In grounded theory (GT) method the quantitative data can become data to be used in generating core categories and theory. According to Creswell and Zhang (2009) grounded theory is a valid method to be combined in a mixed method. They suggest that GT can be used in concurrent and explanatory sequential designs alongside survey research. In the next section GT method will be introduced.

4.3   Grounded Theory Method

Grounded Theory (GT) method was first described by Barney Glaser and Anselm Strauss in *The Discovery of Grounded Theory (1967)* as an attempt to break-away from hypothetico-deductive research. It was developed to minimise the researcher's own preconceptions on the study, which Glaser defines as pre-determined ideas or *a priori* hypotheses that prevent 'theoretical sensitivity' (1978: p.3). 'Theoretical sensitivity' is the 'ability to have theoretical insight into the area of research, combined with an ability to make something of ones insight' (Glaser & Strauss 1967: p.46). The researcher is able to be sensitive to relevant data and

think conceptually about data rather than from pre-determined ideas. This is a key idea in grounded theory (Glaser 1978; Kelle 2007). The goal of the GT researcher is to be 'sufficiently immersed in this world [the area under study] to know it and at the same time has retained enough detachment to think theoretically about what he has seen and lived through' (Glaser & Strauss 1967: p.226).

Theory can be defined as a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena (Strauss & Corbin 1998: p.15). The development and use of grounded theory was first documented in the 'substantive theory' *Awareness of Dying* (Glaser & Strauss 1965). A 'substantive theory' is a theory grounded in data from a particular delimited area of study. A 'formal theory' develops from a 'substantive theory' as a general implication using as widely as possible, other data and studies in the same substantive area and in other substantive areas. Glaser and Strauss further conceptualised *Awareness of Dying* into a 'formal theory' in *Status Passage* (1971).

Anselm Strauss, along with Juliet Corbin, developed GT in a different way with Glaser remaining convinced by the original conception of GT. Glaser's method is know as 'classic GT' or 'Glaserian GT'. In this section classic grounded theory will be described as originally proposed by Glaser and Strauss and developed by Glaser. In the next section some of the differences between classic grounded theory and other grounded theories will be discussed.

Grounded theory is an inductive as opposed to deductive method (Glaser 1978: p.37). Inductive reasoning is process of extrapolating patterns from a range of data to form a conceptual category. It occurs through staying close to the data allowing the theory to emerge from the data rather than from *a priori* hypotheses which is deductive reasoning.

The analytic steps of classic GT are:
1. Collection of data
2. Open coding
3. Theoretical sampling
4. Memoing
5. Emergence of core categories

6. Selective theoretical sampling, coding and memoing

7. Saturation

8. Sorting of memos into theoretical framework

9. Writing up and rewriting (Glaser 1978: p.16)

The steps listed above suggest a linear process that is not actually the case in grounded theory. Each step will be individually explained, however, the process is iterative by constant comparison, moving backwards and forwards between the steps increasing the conceptualisation each time.

4.3.1 Collection of Data

Data can be collected from the substantive area by informal interviewing, focus groups, observation, documents, and even quantitative data. One of the preferred methods is to collect data from field notes made after an interaction not during. But Glaser (1998: p.8) also states that 'all is data' and can be used in grounded theory.

4.3.2 Open Coding

Conceptual abstraction begins with coding. 'The essential relationship between data and theory is a conceptual code' (Holton 2007: p.264). Coding is the ability to abstract a conceptual idea from an incident (or indicator) in the data (*ibid: p.272*). This process provides a concise abstract explanation as opposed to detailed description. Open coding begins soon after collecting the first set of data. Coding is a process of 'fracturing the data' and analysing the underlying patterns with a view to what is happening in the data. Coding begins line-by-line and for a researcher new to grounded theory may be more descriptive than conceptual at this stage.

4.3.3 Theoretical Sampling

Theoretical sampling is specific data collection intended to build the emerging categories and to fill gaps in previous data collection. This differs from data sampling in other methods that may be random or may be designed to capture as much data as possible, such as ethnography. It delimits data collection to prevent unnecessary accumulation of data irrelevant to the emerging theory. Sampling occurs by going back into the field to carry out further interviews, focus groups or

observations within a specific area. Theoretical sampling on any code stops when it is saturated, elaborated or integrated into the emerging theory (Glaser 1978: p.36).

4.3.4 Memoing

Whilst arguing for the researcher to have an 'open mind' to the data, the researcher is also intimately part of the process of generating data. This occurs through writing conceptual memos that represent the researcher's conceptual thinking on the analysis process which then become part of the data. 'Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding' (Glaser 1978: p.83). Conceptual memos are generated from the constant comparative process. At every point in the process the researcher is constantly checking the coding, categories, and memos with the data for 'fit' (Glaser & Strauss 1967: pp.101-15). Glaser (1978: p.3) goes on to state that the researcher cannot discard data to achieve a 'fit'; neither can good ideas be forced onto the data. Instead through the constant comparative process the researcher looks for ways to integrate the data.

Steps 1-4 in the analytic process happen concurrently. There is no need to wait until all data are collected. This process is iterative taking the researcher repeatedly back to the data and forward to conceptualisation as coding and analysis happen.

4.3.5 Emergence of Core Categories

Through the constant comparative process of coding, sampling and memoing the core categories begin to emerge. Each stage becomes less descriptive, more abstract and conceptual but still grounded in the data.

In grounded theory a 'property' is a concept about a category. A category is a higher-level concept capturing the underlying patterns in the data. The highest level of conceptualisation is a core category, below which is a sub-core category. The core category relates most other categories to their properties by accounting for the behaviour. A category that relates to much of the core is a sub-core category. The process of analysing the data is therefore one of developing greater degrees of abstraction and conceptualisation through looking for patterns in the

data and the relationships between the data, codes and categories that lead to a theory of the social and psychological processes occurring in the area of study. Once the core categories begin to emerge in step 5, then the researcher proceeds more selectively.

4.3.6 Selective Theoretical Coding, Sampling and Memoing

'Theoretical codes conceptualise how the substantive codes may relate to each other as hypotheses to be integrated into the theory' (Holton 2007: p.283). One foundational family of theoretical codes is that of the 6C's, causes, contexts, contingencies, consequences, covariances and conditions (Glaser 1978: p.74). This is not the only family and Glaser (2005) goes on to write about numerous others, but also encourages researchers to look for their own. The aim is to find theoretical codes that have sufficient explanatory power for the emerging theory.

Selective sampling and memoing continue to become more conceptual as theoretical codes are used in the theory until the point of saturation when the theory is fully integrated between the core categories and theoretical codes. This is not yet the end of the process as further integration is still necessary. This is achieved through sorting of conceptual memos.

4.3.7 Memo Sorting

Conceptual memos are hand sorted into theoretical frameworks that resemble chapter headings. This sorting is based on the theoretical codes and is therefore conceptual sorting not data sorting. During this sorting process more memos are generated that can lead to increasing conceptualisation and 'condensing the theory' (Holton 2007: p.284). Sorting prevents over-conceptualisation, as the theory has to integrate with the theoretical codes and concepts from which it has come (Glaser & Holton 2004). This process also integrates relevant literature into the theory. Glaser (1998: p.68) recommends proper pacing of reading during the analysis. The literature search is carried out after the theory has been developed.

4.4 Critique of Grounded Theory Method

Apart from the steps shown above, there is little in the way of framework to guide and direct thinking and decision-making in classic GT. Data forms the framework

and the researcher's conceptualisation of it. For a researcher new to grounded theory this can be intimidating and unsettling. As a result modifications to method have been suggested; usually designed to bring more structure and framework to the process, such as, Charmaz (2006) within social constructionism. Confusion occurs when researchers use the term grounded theory without specifying the type (Anglin 2002) or by modifying a type (Ingersoll & Ingersoll 1987; Baker, Wuest & Noerager Stern 1992; Griffin 2005; LaRossa 2005; Shooter 2005). The main contention in grounded theory concerns the disagreement between Glaser and Strauss on methodological differences. Two are compared and contrasted, which are emergence versus forcing, and the accessibility to literature and training.

4.4.1 Emergence versus Forcing

Glaser's (1992) contention is that the method developed by Strauss and Corbin (1998) 'forces' the data rather than allowing the theory to emerge. This can happen through coding, using preconceived ideas and pet codes and premature reading of the literature.

Coding

Strauss with Corbin (1998) developed a method that added more structure to the coding steps called 'axial coding'. They propose a single family of theoretical codes: condition, context, action/interaction strategies and consequences called the 'coding paradigm'. This is very different from unlimited theoretical codes that Glaser proposes (1978: p.74; 2005). Strauss and Corbin (*ibid*: p.181) also added a 'conditional/consequential matrix' described as an analytic device to stimulate thinking about the interactions between conditions, actions/interactions and consequences.

In answer to the first publication of Strauss and Corbin's book in 1990 Glaser wrote the *Basics of Grounded Theory Analysis*, (1992) which is dedicated to comparing what he defined as original 'emergence' GT with Strauss and Corbin's 'forcing' GT. In it Strauss and Corbin's ideas on 'coding paradigm' and 'conditional matrix' are denounced as leading researchers to force the data. Glaser suggests that by focusing so much on 'conditions', the researcher is led along a preconceived theoretical path that does not allow the creativity and freedom in

classic GT. The four criteria of classic GT cannot be applied to Strauss and Corbin's GT as the focus on condition and consequence limits theory formation and forces the data to conform to process. One proponent of classic GT has suggested that 'evolution' of GT is in fact erosion, as Strauss and Glaser's methods are fundamentally different (Noerager Stern 1995).

Classic GT determines that theory should be allowed to emerge from the data through constant comparative method and by staying close to the data. In this way to 'force' certain theoretical codes upon the data is diluting the original method. It is no longer grounded in the data alone, but dependent on the theoretical framework of the method. Remarking on the term 'discovery', Willig (2001: p.43) offers the opinion that grounded theorists are like midwives who deliver a fully formed baby as the discovery process lacking the creativity of other methods. This is directly opposed to Glaser's (1978: p.20) suggestion that the conceptual process is creative; it is an implicit part of the process. Altrows (2006: p.53) states her reason for using classic grounded theory is that Strauss and Corbin's method can be overly prescriptive. She goes on to write that in using classic GT the researcher has to wrestle with uncertainty with a less structured approach. However, this openness and flexibility promotes maximum creativity without forcing the data by a preconceived framework.

Pet Codes

Successful grounded theorists may generate theoretical codes that have such 'grab', that is to say they are interesting, that they look for it everywhere. The danger with this is forcing the data. It may be possible to find the 'pet code' in the next research study, but this may be at the cost of allowing something new to emerge (Glaser 2005: p.117).

Preconceptions

Charmaz (2006: p.9) writes 'I view grounded theory methods as a set of principles and practices not as prescriptions or packages'. Charmaz has re-constructed her own four criteria for GT studies as credibility, originality, resonance, and usefulness that are similar to Glaser's original four. However, she goes on to assert that grounding theories in their contexts strengthens them (*ibid* p.180). This becomes an argument against developing theories into formal theory where a

formal theory transcends context. This argument is supported by Sayer (2010: p.60) who states that meaning can only be understood within context. Indeed in GT one of Glaser's theoretical codes in the 6C's family is context (1978: p.74). However, he goes on to argue that the theory can transcend the context and so the researcher can develop a formal theory.

Keeping an Open Mind versus An Empty Head

Whether one holds a constructionist or other type of epistemology, as explained by critical realism the researcher will have a 'theory-laden' perspective. This will make him/her theoretically sensitive to the area under study. No one is empty headed as Dey (1999: p.251) wrongly supposes Glaser requires. Glaser and Strauss (1967: p.3) assert that they do not expect researchers to be *tabula rasa*, but rather to have the ability to keep an open mind. One way in which this is advocated is by suspending reading the extant literature until after the theory is saturated. This is a view that is not shared by Strauss and Corbin who recommend reading earlier in the conceptual process. Keeping an open mind is a discipline to be developed and practiced by the researcher.

4.4.2 Accessibility to Literature and Training

The accessibility and well written style of Strauss and Corbin's and Charmaz's books, compared with the relative inaccessibility of Glaser's books and style has resulted in the popularity of subsequent, more structured GT methods. There has also been a lack of available classic GT supervisors, which Glaser calls 'minus mentoring', which can result in the researcher becoming lost in the data and unable to progress (Glaser 1998: p.216). However, as more researchers successfully complete their classic grounded theories, support is becoming available on-line and at workshops through the Grounded Theory Institute.

4.5 Risks and Benefits of Changing Analytic Framework

As previously stated grounded theory (GT) has been used in mixed methods research (MMR) within the context of a concurrent and explanatory sequential design study (Creswell & Zhang 2009). The decision to carry out a mixed method study using a grounded theory approach is unusual from a classic GT viewpoint. This is because the study could be seen as being 'preconceived', that is to say,

pre-considered ideas about the area under study affect the outcome of the theory (Glaser & Strauss 1967; Glaser 1978, 1998). Although the overall study had been preconceived, the resulting change of analysis towards theory generation was due to circumstances that were not preconceived.

One advantage of GT is that it is a general method, although most often associated with qualitative research, which presents the option of using GT with the quantitative data (Glaser & Strauss 1967). Glaser argues that 'all is data' and this includes quantitative data (1998: p.8). In the present study adopting a theory-generating approach of what was happening reduces the risk to the overall study as it addresses the main concerns of the participants as important and relevant.

After considering the debates and differences in the grounded theory styles, classic GT was chosen in this study because of the emphasis on 'remaining open to the data' and its approach to 'not forcing the data'. As has previously been described the difficulty in describing the insider/outsider position of the researcher resulted in the need to be able to trust the method process to generate valid conclusions. The rigour in classic GT is in attending to the specific areas Glaser identifies that could result in forcing the data, rather than the structured approach of Strauss and Corbin that may inadvertently force the data through the method framework.

4.6 Validity

Validity is built into the method because 'fit' is another word for validity (Glaser 1998: p.18). The result of grounded theory is not the reporting of facts but the generation of probability statements about the relationships between concepts (Glaser 1998: p.3). Glaser (1998: p.136) explains that there are four levels of conceptualisation in GT. The first level is that of the data, the second is the conceptualisation of data into categories and their properties, third level is integration into an overall theory and the fourth level is formalisation of a substantive theory into a formal theory. A good theory can be assessed by four criteria,

- does it fit?
- is it relevant?
- does it work?

- is it modifiable?

By 'fit' Glaser and Strauss (1967: p.3) mean do the categories fit with the data. 'Fit' is part of the constant comparative process as at each step the researcher refers back to the data. The overall theory generated can then be assessed by how well it fits into the substantive area of the study. The theory must be relevant to the area under study and this question is on the researchers' mind throughout the analysis. The theory needs to be able to explain what was happening in the area under study. Lastly Glaser (1998: p.17) suggests that the theories should be modifiable when new data or new theory is generated. These four criteria can be summed up in another way under the term validity.

Fit versus reflexivity

'Fit' allows the preconceptions to emerge in the process of coding rather than being 'forced' by reflexive thought. Glaser suggests that it is not correct to think of this as reflexivity. Instead he suggests that reflexivity, defined as, 'the process of self-critical self-reflection on one's biases, theoretical predispositions, preferences and so on' (Schwandt 2007: p.260), can keep the researcher locked in and unable to move. In this way Glaser is suggesting that during the conceptual memoing and coding process the researcher needs to be thinking about the data not about self in the process. Hall and Callery (2001) have described thinking about self in the research process as 'naval gazing'. Any preconceptions and biases held by the researcher will emerge through the constant comparative process, when codes or categories that have been forced will be exposed by comparing back to the data.

It is important to note that this statement pertaining to the process of data analysis in GT is not to be conflated with stating that reflexivity in the study as a whole is discouraged. Reflexivity is a critical part of developing validity as has been demonstrated by the need to change from descriptive analysis to theory generation.

Computer Assisted Qualitative Data Analysis

Computer assisted qualitative data analysis (CAQDAS) is often used as a means of improving the overall validity of a qualitative study. However this is disputed by Glaser and Holton (2004) who propose that CAQDAS leads to forcing the data through a linear approach to theory building. Glaser states that GT 'enables the emergence of conceptual theory as distinct from the thematic analysis

characteristic of CAQDAS research.' He goes on to say, 'GT and CAQDAS methods are sufficiently at odds with each other as to be incapable of integration' (2003, 2004). However, it is common to find grounded researcher's using a software package to manage initial data storage, coding and retrieval (Altrows 2006; Holton 2006; Williams, S. B. 2007).

Replicability

Replicability in terms of another researcher coming in to conduct the same research would be possible in terms of the outcome measures but not in terms of GT. In GT a substantive theory can become a 'formal' theory when it transcends the context in which the study was carried out and becomes transferrable and generalisable. However, that is beyond the scope of the present study.

4.7 Insider/Outsider Researcher

The researcher was introduced in Section 1.7 as a pharmacist and mental health professional. Within Christ Church the researcher was a member of the Risk Management team that has responsibility for managing risk issues, for example, self-harm or threatened harm to others. The researcher was also a member of the Women's Pastoral team that has responsibility for co-coordinating care and support of the women in Christ Church. In qualitative research the position of the researcher as either an insider or outsider is an important consideration with respect to the relationship between the researcher and the area under study. The difficulties in stating a single position has been discussed by Holian (1999) as an insider researcher in her place of work. In this section insider/outsider status is discussed within the area of social science. The definitions of an insider/outsider will be explored and the relevance to research and particularly to the researcher's position will be discussed.

In social science an 'outsider' is someone who does not belong to the area under study and is presumed to be able to hold a 'value-free', objective position. However, this is too simplistic as there are two positions of an outsider, one position is an objective outsider (de Tocqueville 1835; Goffman 1959, 1961, 1963) where the researcher is unfamiliar with the area under study and remains so in order to present an outsider's perspective. The other position is as a subjective outsider, otherwise called 'going native' (Geertz 1973) where the researcher aims

to become a member of the area under study in order to develop a deeper understanding.

The insider position can be categorised likewise. The objective insider may be a researcher who is a member of the organisation but is able to maintain a detached observer position, for example, because they are new members (Evered & Louis 1981). The subjective insider can be found in auto-ethnography (Atkinson & Hammersley 2007: pp.204-5) and social constructionism (Charmaz 2006).

4.7.1 In-between Positions

There have been other attempts to define 'in-between' positions. For instance, the description developed by Adler and Adler (1987) of 'peripheral member', 'active member' and 'complete member', where complete member implies the term 'going native'. The 'marginal native' position is where the researcher may be welcomed to the field of study, but is still treated with suspicion or mistrust (Freilich 1970a: p.2). This description seemed closest to the researcher's position in lacking the absolutes of either an insider or an outsider, but there is more complexity to the argument. In previous research on the community Williams (2007: p.42) describes her position as a 'partial insider' also due to the complexity of her role within the community, whereas Charmaz (2006: pp.21-2) emphasises the move from being an observer to a participant in her fieldwork creating different issues for objectivity. In a useful description Dwyer (2009) defines her position as 'the space between'. There are many instances where it may be possible to hold one position or the other, but Merton (1972) suggests the best research will be a combination of both.

4.7.2 Objectivity/Subjectivity

The word insider can be 'value laden', a term used by Sayer (2000: p.58) in critical realism. This implies that there can be a perception that an insider researcher is unable to produce valid research due to bias. Critical realism helped to resolve the issue through addressing objectivity and subjectivity. In making a distinction between these definitions, Sayer suggests that the important point is the judgment put on each word. Objective, in the sense of the search for objective knowledge, can be synonymous with true (Sayer 2010: p.49). Conversely subjective implies knowledge that is not true or merely a matter of opinion. In identifying these judgments on these words, he has identified values held by the different research

positions against each other. Evered and Louis (1981) rightly argue that complete detachment is not possible or realistic. However, the position that can be adopted in qualitative research is that of the emic, etic perspective.

4.7.3   The Emic and Etic Perspective

Coined by Pike (1967) the term 'emic' means an account that comes from a person within a culture and an 'etic' account comes from an observer to the culture. The etic account aims to be culturally neutral. The aim would be to collect data from the emic perspective and analyse and report it in the etic. An account of the balance in emic and etic perspective can be found in Lyon's (2011) work about design ethnographers. This is similarly described by Atkinson and Hammersley (2007: pp.230-3) as the 'participant' and 'analytic' perspectives.

4.7.4   Stating the Researcher's Position

Membership of the community places the researcher as an insider in the study. Membership of the Risk Management team and pastoral team confirm an insider status, but with the added dimension of having a senior more experienced role in the church. The researcher's status as a mental health professional can be viewed by the participants as an outsider position as it was not a role used within Christ Church. Sayer suggests that 'reflexivity is conducive to objectivity in the sense of developing true or practically adequate accounts' (2000: p.61). This argument is also put forwards by Brannick and Coghlan (2007) who define it as 'epistemic reflexivity'. The researcher needs to be aware of trying to hold onto an objective position by suppressing any values or not attending to any values that the researcher might have (Lyon 2011). Taking the argument further Fetterman (1998: p.1) recommends that a researcher enters the field with an open mind not an empty head, this is also a position echoed by Glaser (2005: pp.2-15) in grounded theory. Although Carter and New (2004: p.6) maintain that critical realists can maintain an objectivist approach through the argument that the world is mind independent. Critical realists suggest that thinking about and with values and beliefs is the more usual. To deny values and beliefs may lead the researcher to a false sense of security. Rather the important philosophical position to hold is not that of being theory neutral or theory determined but 'theory-laden' (Sayer 2010: p.78). In recognising the theory-laden position the researcher can then know if he/she is influencing the data. Holding this position can highlight the

preconceptions that the researcher brings into the area under study. Any preconceptions about the community and mental health system give way to only what is emergent in the data.

Summary

In summary, highlighting the failure to resolve either insider or outsider positions does not mean that there is no position but rather that the researcher holds the middle position of a 'marginal native' or the 'space-between', that is grounded in self-honesty and reflexivity and attends to what is explicit in the theory only.

The 'space between' is a description that would fit the complexity of the roles the researcher had in this study. It also implies the opportunity to 'bridge the gap' between the different worlds of the professionals and the participants. The 'space between' can be seen in terms of the methodologies, not only the mixed methods used but also the within grounded theory where the process of doing grounded theory can be seen as attempting to occupy the space in between the data and the conceptualisations leading to a theory.

4.7.5 Acknowledging Bias

The insider researcher needs to be able to trust the method to address issues of bias such as the researcher's own preconceptions and value judgments. Glaser and Strauss (1967: pp.225-7) answer this concern proposing that Grounded Theory (GT) offers a way to resolve these issues through the constant comparative process between data and theory. This process will prevent biases creeping in (Glaser 2003: p.170).

4.7.6 Grounded Theory and Critical Realism

In section 3.4 the discussion on philosophical position in MMR was presented. In this section the adoption of a critical realist position with grounded theory is discussed. It has been suggested that Glaser's grounded theory is positivist (Charmaz 2006: p.7) whereas Strauss and Corbin define themselves as pragmatists. Others have suggested that grounded theory positions itself between realist and post-modernist views (Bryant & Chamaz 2007: p.51). Dey (1999) and Bryant and Charmaz (2007) have all sought to define a philosophical position for

Glaser, whereas Glaser refuses to be drawn and reiterates that GT is a general method. Bryant and Charmaz (2007: p.51) declare GT to be a realist method and then reiterate that it is constructionist. Charmaz (2006: p.10) positions herself very clearly as a constructionist who argues that theory is constructed and not discovered.

Glaser (1998: p.35) reasserts that GT is a general method with no preconceived ideas or philosophies. In this way it is possible to carry out a GT study that may result in an ontological or epistemological position emerging in the theory. It is a 'bottom-up' approach to epistemology rather than a 'top-down' imposition. In addition a critical realist position supports a primary assertion of grounded theory that the purpose of the research is not to discover 'truth' but to find out 'What is happening' with the resulting theory subject to being modified by new research (Glaser 1998: p.17).

4.8 Ethical Considerations

As the researcher was a member of Christ Church there was a need to establish boundaries for both the participants and the researcher. Interview times were mutually agreed and at a location decided by the participants. These times were separate from any other issues or business that might be ongoing within the community so as to make them as distinct as possible.

The participants were informed about confidentiality of information including no identifiable personal details such as job title and age. Christ Church is a small community in which a lot of personal history is openly shared, for example, in group meetings as well as Sunday services. The aim of the researcher was to maintain confidentiality and protect detailed information even if it may be in the Christ Church public domain by the time of completing the thesis.

Participants did not keep their involvement in the study secret. However, the researcher did not disclose that information. On only one occasion was the Risk Management team informed by the researcher of a risk issue as an outcome from the baseline interviews. The participant was informed of this procedure beforehand.

4.9 Data Collection

This section describes the way classic grounded theory (GT) method was used in this study. This will provide familiarisation with the method and give an understanding of how the coding and theory generation process works.

Although the researcher was 'sensitised' to the dissemblance by the participants in the completion of the baseline assessments, the objective of the interviews was not to concentrate on this finding but also to find out about the participants' first six months in Christ Church. The researcher's role is to listen and observe and avoid filtering what is said through own preconceptions (Glaser & Holton 2004). It was in this context that the theory emerged over time about what was important and relevant to the participants.

Data were collected from the in-depth interview transcripts, field notes made during or just after the interviews and the assessments, and email correspondence. The newcomers questionnaire and two further in-depth interviews, that were not transcribed, were used for theoretical sampling to achieve theoretical saturation. In grounded theory these data are considered as primary data and the extant literature is considered secondary data.

4.9.1 Approach to In-depth Interviews

All the participants who consented to take part in the study were asked if they would still consent to be interviewed. They were informed that the researcher was interested in their views about their first six months in Christ Church and the baseline assessments. Each participant agreed to be interviewed. The participants decided the location of the interviews and all first interviews, except one, took place in their accommodation. The participant information sheet described how the interviews would be recorded using a digital voice recorder and the interview would be transcribed for analysis using coding and categorising. The participants were also informed that all data would be used anonymously and no personal identifiable data would be used in the final thesis. They had been informed that the interviews would be around about an hour in duration and that they could talk about anything they wanted to concerning Christ Church and how the first months had been for them. In other words within the narrative culture of Christ Church (Clarke 2011), they were invited to tell their story.

The interviews began by inviting the participants to explain how they had found taking part in the baseline assessments and completing the first batch of outcome measures and also how they had found the first six months in Christ Church. This start enabled them to tell their story, being interrupted only to ask clarifying questions or to offer encouragement. Some participants were more able to communicate their opinions than others. Those that were not forthcoming were not pressed into saying more than they wanted to. This resulted in a variation in the quality and quantity of the interview data, but all data were used and treated in the same way.

Glaser recommends that data collection and data analysis is simultaneous. However, four interviews had been collected before coding started. Coding began on one interview at a time. Data were collected from eight in-depth interviews. Email correspondence from three participants regarding their experiences and views of the baseline assessments was received. In addition to data from the newcomers questionnaire was collected that was used for theoretical sampling.

4.9.2 Recording

Recording the interview was part of the original design, but Glaser does not advocate the use of recording because complete description is not necessary in GT (1998: p.105). He goes on to explain the problems associated with recording which include, no delimiting of the data, delaying theoretical sampling, getting lost in overwhelming amounts of conceptually repetitive data that pressurises the researcher towards description and reduces the comfort of the participant by affecting confidentiality (*ibid* p.107-113). He argues that recording will lengthen the process by several months and could reduce richness of the conceptual theory. However, he admits that research groups will find recording easier in order to share data and confirms that GT can be used with any form of data. Within Christ Church recording meetings and sessions instead of note taking is normal. The researcher concluded that although not Glaser's ideal, it was a suitable means of data collection. One benefit of recording is the ability to maintain eye contact with the participant. An Olympus WS-300M digital voice recorder was used that enabled data to be downloaded directly onto a computer for transcribing. This also enabled the researcher to listen to the recording on the computer whilst simultaneously reading the transcript during the coding process.

As Glaser had warned, a large amount of data was generated that took a long time to analyse. The recording also altered the dynamic of the conversation as the following illustrates.

<div style="border:1px solid black; background:#eee; padding:1em;">

FN-80228-1   First Interview with F1

I was acutely aware of the recorder. Although it was very small and made no noise it seemed vast and obtrusive. F1 also at times looked at it whilst she was talking. I was aware that she was making comments for the benefit of the recorder. I was uneasy with it. I wanted F1 to talk and express her views without being led by me. So I kept more quiet than usual. This is not our usual kind of interaction.

</div>

The researcher noted that at the end of one interview the participant; relieved it was over, slumped back into her chair. The researcher had been unaware of the effect of recording the conversation. How this affected the quality of the data is unknown. This suggests that Glaser's non-recording approach may be more naturalistic.

4.10 Data Analysis

Data analysis proceeded along the steps outlined by Glaser in Section 3.3 starting with the constant comparative process of coding, theoretical sampling, conceptual memoing and emergence of core categories. Then progressing on to theoretical sampling, coding and memoing to saturation of the theory. In this section the way in which the grounded theory analysis was carried out will be presented using illustrations from the data. The process from coding the data through to the emergence of core categories will be described. In the text codes and categories will be underlined in order to highlight them.

4.10.1 Coding

Each interview was transcribed simply, with no reference to pauses or other non-verbal cues with the exception of one or two indications towards laughing in order to clarify the meaning of the sentence. The transcripts were imported into HyperRESEARCH software, a computer assisted qualitative data analysis software (CAQDAS), for storage, coding and retrieval. HyperRESEARCH stores data and enables codes to be assigned to portions of the text. These codes are stored in a text reference manager and in a catalogue called a code list editor. The

software enables searches to be conducted of the codes and the source data. This is useful in managing large numbers of codes and relating them back to the text and across all source texts for comparison. Coding was carried out whilst listening to the recordings as well as reading the transcripts in order to pick up nuances and pauses, to 're-live' the moment. This is also a practical way of enhancing validity as this served as a check for accuracy of transcription and accuracy of understanding through being able to hear voice tone, inflection, pauses and laughing. Although Glaser does not recommend word-for-word data collection, using the data in this way helped to preserve a sense of reliving the moment.

During the analysis validity for the developing theory was sought by discussing coding and categorising within individual and group supervision. Field notes, memos, emails, and the newcomers questionnaire were assigned a simple code using the initials of the types of document. Field note is FN, conceptual memo is CM and emails are E. These initials are followed by the last digit of the year, the month and date, followed by a number that corresponds to the number of memos written on that day. For example, the first conceptual memo on 12th August 2010 becomes CM-00812-1. The newcomers questionnaire was coded NQ followed by the participant code and the question number, for example, NQF519.

Open Coding

Data analysis begins with open coding beginning with one transcript working word-by-word to line-by line coding. The coding process took several attempts. Initial coding with single word descriptors such as 'pretend', 'therapy', and 'judgment' did not convey the processes that were occurring. The researcher felt inhibited by the need to get the coding 'right' and fearful of getting it 'wrong' and locked into the goal of finding 'proof' (FN-00111-1: Notes and Thoughts). Awareness led to accepting the data as an account of what was happening from the participants' perspective. The researcher developed the discipline of coding of 'chunks' of text using gerunds or verbs to maintain a sense of process. For example, excusing, exerting, performing, doubting, being, choosing, believing, explaining, belonging, feeling and risking. The participants' own expressions or words were not always used to name codes. The aim was to code as conceptually as possible from the outset. When satisfaction was reached with the coding of the first transcript then the researcher moved on to the second and so on.

Illustration of coding from the data:

Table 4.1: Code Being offered treatments that gave no hope of change

Open code	Being offered treatments that gave no hope of change
Incident 1	And we are just going to find the right drug to blot it all down. And I had had cognitive therapy in the past. And I guess looking back because I can intellectualise things for myself it just fed that and it fed the trying to be my own saviour. If I work it all out logically, if I go these certain steps in this order and it became like it's own religion, do you know? So in the end not terribly helpful because it still didn't get through into the core of me and it was back in my control zone supposedly. F1 text ref 6953,8156
Incident 2	I experienced my own 'insanity' and was not talked to…the feeling is that nobody knew what to do. Patients seem to be 'drugged up' and one hopes they will come out of their breakdown as a matter of course. NQF322
Incident 3	But the last time I was in hospital he gave me a different set of [medication] which he didn't really give me any help with and he said get this prescription, good luck. F4 text ref 1173,1895

Table 4.2 Code: Choosing unreality

Open code	Choosing unreality
Incident 1	The need to get out of reality every so often is still there. F2 text ref 13494,13565
Incident 2	I think I would have been wanting to live in a reality to myself that it was all going to all be ok it wasn't as bad even though it was worse. …I probably thought that if I admitted to how bad I felt I would probably put myself in hospital. F2 1903,2322
Incident 3	So that is probably where there is a level of denial because I have to some extent I have got used to. So I don't have to face things. F1 Text ref 8185,8521

Table 4.3 Code: Community has been a life-saver

Open code	Community has been a life-saver
Incident 1	And so I suppose when I first came here there was this feeling of I have come to the one place on earth that can save me. F1 text ref 12152,12574
Incident 2	…just that if I hadn't come to the community I think I would be dead. So even, yea I think I would be, as I was very close to it before I came. F2 text ref 21284,21635

Table 4.4 Code: Relationship formed through support

Open code	Relationship formed through support
Incident 1	I have a mentor I don't feel alone in my journey NQF740
Incident 2	You can help others and they can help you. You can work together with others and get further into your issues than you would do solo NQF540
Incident 3	… and even after the course I found it really hard but the people were so lovely, and we have all been in email contact and 'well done', 'I want to give up', 'yes so do I'. That kind of support has been really helpful. F4 Text ref 3380,3667
Incident 4	Having a mentor helps because it's at least one person making you see and they know you. F5 text ref 13737,14211

Selective coding generated 166 substantive codes.

4.10.2 Theoretical Sampling

The constant comparative process enabled the initial coding phase to become more selective which is when codes are selected for significance and/or frequency. An example of this is the development of the fear codes in chapter section 5.6.5 Open coding resulted in 87 indicators that when compared back to the data and with each other became eight different secondary codes. Theoretical sampling begins by looking for data that strengthen category formation through broadening, deepening, disconfirming and confirming. This process also helped to identify one set of data from a different context. Instead of referring to mental health services these data referred to general health services. This was a useful distinction to make early in the analysis and helped to develop and conceptualise the theory.

4.10.3 Conceptual Memoing

Memos were sparked by ideas about connections, links, theories about why and how incidences were occurring. Memoing was the opportunity to begin moving

beyond the data and exploring the relationships between the categories and their properties. In all 124 memos were typed and stored electronically. They ranged in size from small single paragraph to two page documents.

The conceptual memos presented below illustrate the analytic process of moving from raw data to categorisation. Some memos contain a HyperRESEARCH reference number that corresponds to the exact place in the text. The time line of these memos demonstrates this process took place over several months.

CM-00323-2 Permission to self-deceive

For some there is the need to feel that they have "been heard", "been listened to". If this does not happen then the person will shut down and not elaborate on any details and 'withhold' information about themselves. The deception begins.

Examples from F2 interview: code-intentional withholding of truth (text ref: 4704,4957)

A treatment is offered, for example, CBT. Self-deception begins as the person is told how well they are doing on the treatment. However, the treatment has not really touched the person at a deeper level.

Example from F1-2 interview: code-self-deception (text ref: 8192,9038).

CM-00628-2 Realising others are important

In listening to others in the community the participants are not judging them Instead they seem to be accepting what they have heard. In the acceptance of the stories they are realising that these others are important and have significance. Then deciding that if others can have significance then so can they and it seems to be infectious, like hope.

These illustrations demonstrate the conceptual thinking that was occurring during the coding process that leads on to the emergence of categories.

4.10.4 Categorising

Whilst the HyperRESEARCH computer package was useful in managing the enormous amount of data for open coding, it became a hindrance in forming

categories and relationships between categories. The limitations were noted in the following field note,

> FN-90221-1 Freedom from software
> *Last week I suddenly decided whilst reading Kathy Charmaz's book to start writing post-it notes rather than to keep coding on HyperResearch. I found this quite liberating and completely freed up my thinking as to what was happening.*

As the process of focused coding continued it became easier to identify codes that could be grouped together into categories (see Appendix X). This was done by hand, printing out the codes and individually sorting them into groups with similar properties. Some of the coding names were elevated to become category names and in other instances a new category name was given. Categorising continued until all the data had been adequately accounted for. All of the codes could be categorised in 35 different categories.

Below is the illustration of how the category of <u>Fear being realised</u> emerged from the codes and from the data.

Table 4.5 Category: Fears being realised

Code	Text reference
Feels falsely accused	He kind of inferred that I was non-compliant which was not true. It feels like I have been labelled all those things, non-compliant essentially, whatever. F2
Loss of control	So I have only got bits of information that I have never had before and like when you are young your parents go with you and they tell your parents do this and you've got no control and no knowledge yourself and I think they just assume that you pick it up or something. F4
Perception of being judged by professionals	Most mental health professionals, not just me but treat you as a kind of enemy really. "You know, you are playing the system, you are just doing this so we'll do that", so I can't see the point really. F2
Deceived by professionals	And then you go to the nurse and she asks you really sneaky questions that you don't realise what you are being asked until she whips out a form and says make an appointment to see the doctor. She said they might not put you on anti-depressants and I was like what do you mean, they might not? F4
Collusion between professionals	I think as a patient you feel quite powerless. So if one doctor tells a nurse and nurse tells so and so. The professionals listen to each other, they don't listen to you as a client. I mean there might be the odd exception around the place. F2

4.10.5 Selective Theoretical Sampling

Up to this point the newcomers questionnaire (see Appendix I) had not been analysed qualitatively. These data were used in two ways as described in section 5.6.4. For grounded theory they were used as a source for theoretical sampling and were coded in the same way as the other qualitative data collected. It confirmed the coding process of the interview data and also highlighted another code, difficulty joining the group, illustrated by the following excerpts:

> **NQF5-41** It's full of broken people trying to get well which is great [when] things are going ok for people but when it's not it can make things for you a little tougher. Sorta like a domino effect also someone else's baggage may work up your own.

> **NQF3-41** I suppose it's full of people who have problems with relationships- that makes it harder - also fears and damage. I tried to make friends with a couple of people – but they and I are so damaged that we got nowhere - for now!

Additional sources of data for theoretical sampling came from quotes from the participants in field notes and also email communication from the participants, as well as two further unstructured interviews. Theoretical saturation had occurred when no further codes emerged from the sampling.

4.10.6 Theoretical Coding

Many of the existing theoretical codes could be applied, including the more commonly used basic social process and basic social psychological process and the 6C's of causes, contexts, contingencies, consequences and conditions (Glaser 1978: p.74). The theoretical codes of conditions and consequences are used in the following two conceptual memos:

CM-10126-1 6C's of GT

Primary concern: nothing worked for them before and not been helped before

Consequences

'Power relationships' may result in damage in vulnerable individuals (by increasing fear, employment of coping and defence strategies)

Solution

Develop different relationships (CCD [Christ Church] is not immune from the risk of power relationships especially through professionalisation and structuralisation)

What are some of the **properties** (characteristics) of the **category** 'power relationships'?

Inequality, hierarchy, judgment, mocking, them and us, assumptions, preconceptions, lack of empathy and rapport, lack of trust and fear.

What are some of the **properties** of the **category** 'mutual positive relationships'?

Equality, non-hierarchical, non-judgmental, accepting, open and transparent, listening, engendering feelings of worth and esteem.

Leads to **a theory of personal positive change.**

Paired opposites of powerlessness and control

CM-10211-1 **Category of Power Relationships**

Properties of Power Relationships

- Emotional contagion – FEAR is a cause, condition and a consequence that drives DOUBT
- Being a patient and becoming the enemy
- No Choice
- 'Them and us'

Expectations of professionals – need to know in order to help or control

Expectations of patient – need to be helped but to remain in control

Consequences - Leads to lack of TRUST
Consequences - Deception
Conditions – TESTING in the form of mental health state exam and other rating scales

It is easy to apply the 6C's theoretical codes to everything and not go beyond this conceptualisation. However, other theoretical codes were used to look for relationships between the categories. So, for example, strategy, identity, cutting points, degree, process, interactive, paired opposites and social control could all be applied to the theory. An illustration of this is the conceptualisation of mutuality and power (see section 5.13.1) through applying the theoretical code context. Using the theoretical code of context led to the discovery of the importance of mentoring relationships as distinct from general relationships in Christ Church.

4.10.7 Saturation

Saturation of the theory occurs when theoretical sampling and coding no longer generates new categories. At this point all data can be accounted for. However, this is not the conclusion of the analysis as sorting the conceptual memos further aids integration of the theory through the application of more theoretical codes.

4.10.8 Conceptual Memo Sorting

During the analysis of the categories the conceptual memos were printed out. The longer memos were cut up into smaller themed memos. These were then physically placed into piles relating to categories and their properties, and the relationships between them. Further conceptualisation about what was happening occurs when the researcher moves beyond thinking about individuals towards thinking about 'units'. The process of sorting enables the researcher to consider more theoretical codes to help integrate the theory.

The process of higher conceptualisation through whilst memo sorting can be illustrated by the following development of categories to sub-core categories;

Table 4.6 Development of sub-core categories

Category	becomes	Sub-core category
Power relationships	⇒	Pathogenic relationships
Shrivelling identity	⇒	Losing self
Trapped by fear, shame and hopelessness	⇒	Pathogenic emotion
Positive relationships	⇒	Salugenic relationships
Growing identity	⇒	Finding more of self
Self-reflection and Self-awareness	⇒	Salugenic emotion

This process will be presented in the next chapter. The overall theory was integrated by using two theoretical codes of incongruence and congruence to provide an explanation of what was happening in the newcomers to Christ Church.

4.11 Summary

This chapter has described the way in which grounded theory is used in practice, how the categories are built from the codes and then using theoretical sampling to achieve saturation of the data so that no new codes emerge. The actual emergence of the theory in terms of how the codes and categories relate to each other, the pattern that emerged in the data that built towards the theory will be described in the next chapter. The theory has not been developed beyond level three conceptualisation as it remains in the context of Christ Church.

In the next chapter the grounded theory analysis will be presented including the emergence of the codes and categories, and uses of the theoretical codes will be explained and described. The theoretical codes of incongruence and congruence that integrate the theory will be defined.

5 Findings

5.1 Introduction

In this chapter the quantitative and qualitative findings will be presented. The findings from the baseline assessments that resulted in a change of analytic framework in the study are presented.

The results of the quantitative data collection, which include the data from the Mini International Neuropsychiatric Interview (M.I.N.I.) diagnostic interviews, Clinical Global Impression Scale (CGI), Symptom Checklist 90 items-revised (SCL-90-R) and the World Health Organization Disability Assessment Schedule –II- 36 item (WHODAS-II) are shown. Finally the grounded theory analysis is presented.

5.1.1 Study Drop-Out Rate

The drop out rate was 44%, which included the only male. The reasons given for drop out are:

- Moving away from community for work and family reasons: This person has since moved back into the community.
- *"Felt unwelcomed, judged. Felt abandoned and betrayed"* [when one of the founders of the community moved away]. *"Fear that the other leader was going too."* This person has since become a member of the community.
- Moved out of community to join another church. Christ Church not meeting needs.
- *"Can't do God. Don't feel that people were really there to support."*

5.1.2 Results of the M.I.N.I. Diagnostic Interview

The M.I.N.I. diagnostic interview provides evidence for past and present diagnoses. It allows the interviewer to determine primary and secondary diagnoses. Primary diagnoses are the main or only diagnosis. For instance, bipolar disorder is a primary diagnosis with social anxiety disorder or alcohol dependence being considered a secondary disorder. However, where no major disorder is diagnosed social anxiety disorder would become the primary diagnosis. The tables below demonstrate the findings from the M.I.N.I. interview. The first

table presents the primary diagnoses and the second table the secondary diagnoses.

Table 5.1 Axis 1 primary diagnosis from M.I.N.I. diagnostic interview N=9

Primary diagnosis	Number
Number of participants with a diagnosis	8
Number of participants not meeting criteria for a diagnosis	1
- Major depression	3
- GAD due to medical condition	1
- Bipolar affective disorder II	2
- Dysthymia	1
- Posttraumatic stress disorder	1

Table 5.2 Secondary diagnoses from M.I.N.I. diagnostic interview (N=9)

Secondary diagnoses	Number
Obsessive Compulsive Disorder (OCD)	2
Alcohol dependence	2
Dysthymia	2
Social anxiety disorder	4
Posttraumatic stress disorder (PTSD)	2
Substance induced mood disorder	1
Bulimia	1
Specific phobias	
Generalised anxiety disorder	1

These findings demonstrate that the newcomers presented with a wide range of medical and psychiatric issues. The potential confounding nature of the thyroid condition made a clear psychiatric diagnosis very difficult without a detailed examination of medical notes and medical examination of the person. This is illustrated the importance of stating that the researcher's purpose in collecting this data was not for treatment purposes but for indicators of caseness. However, the wide-ranging results also confirm the choice of broad rating scales such as the self-report Symptom Checklist-90 items-revised (SCL-90-R) measuring the participants' experiences rather than any diagnostic specific tool.

The relative high percentage of participants with social anxiety disorder is interesting to note as these participants had chosen to join a community with an emphasis on socialisation.

One participant had a previous diagnosis of depression but was diagnosed with bipolar disorder from the interview. This is not uncommon with bipolar disorder where patients typically present for help with depression but avoid help with hypomania or manic symptoms. Three did not have a prior diagnosis and had no previous contact with mental health services. From the M.I.N.I. interview, one was identified as having dysthymia, one with posttraumatic stress disorder (PTSD) and one with generalised anxiety disorder (GAD) due to medical condition.

General Medical Conditions

In addition to various mental disorders the results showed three participants had chronic medical conditions. Two of these conditions, type I diabetes and thyroid disorder are known to be associated with depression. The thyroid disorder was described as controlled and the diabetes poorly controlled.

Summary

A result of using the M.I.N.I. interview was the anxiety it produced in each of the participants. Nearly all contacted the researcher after the interview to ask for reassurance. The participants sometimes found the language in the M.I.N.I. difficult to understand and required interpretation. All newcomers, except one, provided responses to the M.I.N.I. that indicated past or current diagnosable disorders. This was an unexpected finding as from the outset the researcher had presumed that some participants would not have mental health issues. This assumption was based on the existing membership of Christ Church.

5.2 Newcomers Questionnaire Data

Participants completed the Newcomers Questionnaire (see Appendix V) after the baseline assessments. The aim of the questionnaire was to gather demographic data (see chapter two) and also to ask a broad range of simple questions that may generate sensitising issues that could be followed up in the in-depth interviews. The subjects ranged from perception of own health, including mental

health, previous experience of the health services, participation in church and view of spirituality. The participants were able to take the questionnaire home to complete in their own time. The disadvantage of this strategy was that only 6 out of 9 questionnaires were returned.

The data from the Newcomers Questionnaire has been used in two ways. The first way is in the presentation of the demographic data and pertinent results from that questionnaire. This is data that was not directly used in the development of the grounded theory. This is in order to give the reader an understanding of the participants that includes their perceptions and experiences and a flavour of Christ Church including the participants' initial perceptions of Christ Church. The second way in which the questionnaire was used was as theoretical sampling in the grounded theory, which is described in section 5.14.3.

5.2.1 General Health

Participants were asked how they rated their general health, mental/emotional health and general wellbeing (see Appendix V: Q's 11,12 and 13).
Results show that;

- General health 100% rated themselves as having average health
- Mental/emotional health 83% rated poor and the remainder average
- Well-being 66% rated as poor and 33% as average

These results are not surprising as it would be expected that newcomers to the community would have a reason for joining that might be health related.

5.2.2 Social Activity

Participants replied that prior to joining Christ Church they saw friends on average once a week and family on average less than this. They rarely attended social activities. The nature of these relationships, as commented above, was not explored. After moving to Deal, the participants were living in some form of shared accommodation and not living alone. This is the communities' preferred option for new members.

5.2.3 Christ Church and Spirituality

The questionnaire sought to gather data on how the participants had become aware of Christ Church and their perception of moving to Deal and joining the community.

Q29   How did you hear about the community?

- N=6   5 replied friends and 1 family.

Q31   Did you move to the area to join Christ Church?

- N=6 Five answered yes and one No

Q 32, 34 and 35 are related to the moving process.

- Each of the participants suggested that the moving process was hard or very hard. The responses were that a pre-moving visit had been, helpful, okay, very unhelpful or not answered.

- Lack of communication from the community seemed to be the biggest cause of anxiety for most. Although other themes that emerged included needing to take responsibility for yourself and disillusionment over the true nature of the community.

- One respondent expressed disillusionment in the written response that was inconsistent with regard to the relationships within the community.

Q33 What factors influenced your decision to join Christ Church?

- N=6   4 replied specifically mentioning friends.

The most popular route into the community appears to be word of mouth from friends. Some of these friends were already members of the community and others had been participants of workshops run by the community. The nature of these friendships and therefore what process was involved in the decision to join the community was not explored in the interviews. The data shows that each individual made their own choice to join the community, as a third party or agency had not referred them.

Spirituality

Q38 What do you understand by the word 'spiritual'?

- N=6   4 responses defined spiritual as the 'unseen'
- 3 responses related it to God
- 2 responses described spiritual 'real'
- 2 linked the spirit with emotion or feeling

"seeing things from a different perspective"

"the core/heart of things of us as human beings"

"almost more real than what can be seen"

Q39 Would you describe yourself as a spiritual person?

N=6   Yes=4,   No=2

Please give reasons for this answer:

- One respondent defined a spiritual person as someone who could see angels and demons and 'weird things', even though defining spirituality as the 'unseen world'.
- Five related being spiritual to having meaning, fulfillment, being human and related to God.
- One respondent did not mention God at all.
- The reasons cited for not being spiritual were that of not being able to hear from God and having lost her faith.

"Finding God and trying to imitate him one finds more peace and fulfillment"

"spiritual dimension is as real as our physical"

"I can't hear God"

The responses indicate that for these participants spirituality was linked with God and involved meaning, fulfillment and the core of human beings. Loss of faith in God equated to loss of being spiritual. Spirituality was considered 'real' and important even though unseen. For some it was linked with emotions and involved communication between self, others and God.

This definition helped to confirm the use of critical realism as a philosophical basis for this thesis as it too recognises the different levels of what is 'real'. Critical realism gives equal importance to knowledge of what is seen and what is unseen so that each can have equal meaning and relevance to the study.

Summary

The responses from the questionnaire data indicate that personal relationships were a key reason for joining the community rather than being referred by services. However, the process of moving to Deal to join the community was not

an easy one and one that the community could manage better in the future. The definition of spirituality was broad and encompassed the meaning of life and being human. For most it involved a relationship with God even though for some that relationship was perceived to be broken.

5.3 Findings from the Six-Month Assessments

The findings from the six-month assessments were presented briefly in chapter three and demonstrated the need to consider the study in the light of low recruitment and the disclosures made by the participants.

5.3.1 Participant Numbers

At this stage in the study there were nine recruits which was fewer than had been predicted from previous membership analysis. This meant that the study was not going to achieve power significance, as no further recruitment was possible without significantly lengthening the whole study. Furthermore all the participants, except one, were female. This was also unexpected in relation to previous data. Despite this setback the decision was made to continue to collect the quantitative data rather than completely redesign the study.

5.3.2 Disclosing the Truth about Concealment

The most significant finding came whilst conducting the six-month assessments. At each assessment the participants admitted to dissembling in different ways. This took the form of either lying or deliberately withholding information at the baseline assessments. The reasons given were fear of the researcher, fear of the mental health services, fear of being sectioned and lying out of self-deception. This finding resulted in reconsidering the study design.

5.3.3 Disclosing Fear of the Researcher

The fact that the participants had disclosed the dissemblance at the six-month assessments suggests that something different had happened in the relationships between the researcher and the participants in the two occasions. These findings suggest that the participants' perception of context had changed in the two assessments. Contextual dissemblance is the term used in the present study to convey the reason stated for the dissemblance of the participants at the baseline

assessments. This required a different approach to the issue and led to the decision to use grounded theory method to generate a theory of what was happening.

5.3.4 Discovering the Main Concern of the Participants.

However, this finding led to changing the analytic framework of the qualitative method from ethnography to grounded theory, which allowed the researcher to explore the participants' concerns regarding the baseline assessments. Grounded theory provided a systematic approach to generating a theory of what was happening as opposed to a broad descriptive ethnography of Christ Church.

5.4 Results of Quantitative Study

The results of the individual outcome measures will be presented. The results from the Clinical Global Impressions Scale (CGI), Symptom Checklist-90 items revised (SCL-90-R) and the World Health Organization Disability Assessment Schedule-II (WHODAS-II) will be presented. These results need to be understood from the point of view of earlier statement about the dissemblance of each of the participants in the baseline assessments.

5.4.1 Comment on the Repeated Assessments

The repeat assessments were either instigated by the participants or by the researcher. The participants requested to repeat outcome measures because they had felt that the original assessment had not accurately reflected their current status. This occurred because the timing of the assessments had fallen after a particularly difficult event or in the middle of challenging circumstances. The interesting aspect of this is that these participants demonstrated self-awareness regarding the events and circumstances on their state of health and well-being.

In another case a participant was asked to repeat the assessments as the first attempt had resulted in unusually flattened responses that appeared to be incongruent with their presentation. However, from validity data concerning the SCL-90-R the flattened scores do not appear to be due to significant minimising of symptoms or 'defensiveness' (Rogers, R. & Bender 2003: p.110) (see comment in section 5.4.3). It later became apparent that this participant had a recent routine

appointment with the General Practioner (G.P.).   At this appointment the participant had completed a routine rating scale (it is not known which) more honestly and openly than had done previously. However, this resulted in higher than usual scores, which alarmed the G.P. who switched medication and required more frequent visits with a view to referring to secondary care. This escalation caused fear and anxiety in the participant who then flattened the answers to the outcome measures in this study.

5.4.2 Primary Outcome Measure-Clinical Global Impressions Scale

The Clinical Global Impressions scale (CGI) is an observer rated scale using all available information including observation and general impressions of the person to determine whether there is any improvement over time.

Table 5.3   Clinical Global Impressions Scale   N=5

	Baseline	6 months	18 months	18 (repeat)	24 months	24 (repeat)
F1	4	3	4		0	
F2	4	3	2		1	1
F3	1	3	2			
F4	0	2	0		0	
F5	3	3	3	4	3	

Key: 0=normal, 1= borderline mentally ill, 2= mildly ill, 3= moderately ill, 4=markedly ill, 5= severely ill, 6= among the most extremely ill patients.

Key points

F1 changes from an 18-month score of 4 to a 24-month score of 0 on presentation only. Previous to the 24-month interview the participant had presented as anxious, very talkative and anxious to demonstrate change. At this final interview there was a complete absence of this behaviour. However, this should be noted in comparison with the SCL-90-R scores that will be discussed in the next section. The results demonstrate that there was gradual improvement in scores from F2 over 24 months and inconclusive results from other participants.

5.4.3 Secondary Outcome Measure – Symptom Checklist-90-items-revised

The Symptom Checklist-90-items-revised (SCL-90-R) generated data on the individual symptom domains as well as global scores such as the global symptom index (GSI), the positive symptom index (PSI) and the positive symptom total (PST). Each of the different global scores reflect different aspects of psychological distress. The GSI is a single measure of current level or depth of the disorder, the PSDI is a measure of symptom intensity and the PST is a measure of the number of symptoms regardless of the level of distress. The definition of a positive risk or a 'case' for a psychiatric disorder is a GSI T-score greater than or equal to 63 (Derogatis 1994: p.56).

Table 5.4   SCL-90-R Global Severity Index (GSI) T-scores   N=5

	Baseline	6 months	12 months	12 (repeat)	18 months	18 (repeat)	24 months	24 (repeat)
F1	68	62	65	69	>80		73	
F2	71		>80		59	72	72	64
F3	37	52			61			
F4	69	72			66		56	
F5	60	72			50	67	67	

Key > 50= above norm, >63= caseness, >80 extreme severity of symptoms

On the basis of the definition of caseness F3 did not meet this criteria at all. F4 demonstrated as symptom reduction over the two-year period. F1, F2 and F5 had fluctuating results with F1 demonstrating caseness throughout and F2 and F5 demonstrating scores below caseness at times.

According to Derogatis (1994: p.58) the validity of the SCL-90-R has been researched and the findings suggest that in non-patient populations PST raw scores of ≤ 4 in females are suggestive of 'faking good' (minimising symptoms). PST raw score of > 60 suggest 'faking bad' (exaggerating symptoms). Likewise extreme scores on the PSDI can be indicative of 'faking good or bad'. PSDI raw scores of >3.5 in females is 'dramatic' and combined with high scores across all the dimension scales is indicative of the respondent trying to communicate extraordinary levels of psychological distress.

Table 5.5 SCL-90-R Positive Symptom Distress Index (PSDI) Raw scores N=5

	Baseline	6 months	12 months	12 (repeat)	18 months	18 (repeat)	24 months	24 (repeat)
F1	2.02	1.30	1.36	1.56	2.35		2.04	
F2	2.39		3.04		1.12	2.38	2.40	1.42
F3	1.41	1.24			1.35			
F4	2.34	2.40			1.77		1.37	
F5	1.2	2.63			1.32	2.15	2.65	

Key <1.0= no psychological distress, >3.5= extreme symptom intensity

Table 5.6 SCL-90-R Positive Symptom Total (PST) Raw scores N=5

	Baseline	6 months	12 months	12 (repeat)	18 months	18 (repeat)	24 months	24 (repeat)
F1	64	56	61	75	68		70	
F2	59		76		43	64	62	55
F3	39	34			46			
F4	50	69			61		30	
F5	49	54			52	48	39	

Key <4= suggestive of faking good symptoms, >60= suggestive of faking bad symptoms

Comparing this to the current findings demonstrates that the participants were not 'faking good or faking bad' to a significant degree despite their disclosure that they had dissembled at the baseline assessments.

However, comparing the CGI and the SCL-90-R results there is a discrepancy mostly notably for F1, where the CGI score at 24 months = 0 (normal) compared to SCL-90-R GSI = 72 indicative of caseness, which was the same score as at baseline. At the end point of the study F1 wanted to be able to demonstrate change both to the researcher and to herself.

In the CGI, F2 presented as consistently making positive personal change, this is in contrast to the higher SCL-90-R scores that suggest symptomatically no improvement. F5 presented well in the CGI scores but the SCL-90-R scores reflected incongruence with how she presented and how she was feeling.

As Derogatis (1994: p.28) proposes the test-retest validity of the SCL-90-R is good as demonstrated by the retests on F1 at 12 months and F2 at 24 months. Although requested by the participants the scores were not demonstrably different.

However, the retest requested by the researcher for F5 at 18 months produced a significant difference.

There are incomplete data for F3 due to a number of difficult personal circumstances for this participant. This participant also found completing the forms quite challenging demonstrating great difficulty making decisions.

F4 presented well on the CGI throughout the study, except at the six-month interview where she gave the researcher cause for concern about her mental health.

The results from this outcome measure do not demonstrate any trend positive or negative. The exception is in the 24-month score for F4 who showed an improvement, but this is a single score and therefore it is not known whether this is an isolated score or the part of a trend. The use of both an observer and self-report measures demonstrated correlation between the two suggesting that the dissemblance disclosed by the participants was not significant. There was one discrepancy in the results from F2 as noted above. The lack of conclusive results may be due to small sample size and/or other factors such as choice of outcome measures. The comparison between the results of the PST and PSDI suggest that the participants had not been 'faking good' or faking bad' to any significant degree. These results will be discussed in the next chapter. One of the individual items on loneliness from the SCL-90-R was used in the grounded theory (see section 5.8.2).

Table 5.7   SCL-90-R Q 29 – How much were you distressed by: Feeling lonely N=5

	Baseline	6 months	12 months	12 (repeat)	18 months	18 (repeat)	24 months	24 (repeat)
F1	1	1	1	1	2		2	
F2	3		4		1	4	2	1
F3	1	0			1			
F4	1	2			1		1	
F5	2	3			2	3	3	

Key 0=Not at all 1=A little bit 2= Moderately 3= Quite a bit 4= Extremely

5.4.4 Secondary Outcome Measure- World Health Organization Disability Assessment Schedule –II

The World Health Organization Disability assessment schedule–II-36 item (WHODAS-II) is a global disability outcome measure that encompasses physical, mental and emotional illnesses that result in an inability to cope with daily activities and functioning.

One weakness of the questionnaire design relates to question H5 that asks, 'how many days did you have to cut down on activities because of your disability?', it is a relative question as one person's baseline is not the same as another's. For instance, one person's baseline may be that they can only go out of the house for important routine appointments; cutting down might mean having to cancel the appointment and not going out of the house at all. This becomes important after joining the community where baselines will begin to be questioned, that is to say, what is 'normal' functioning?

Question H2 asks 'How much did these difficulties interfere with your life in the last 30 days?'

Table 5.8   WHODAS-II Question H2 N=5

	Baseline	6 months	12 months	12 (repeat)	18 months	18 (repeat)	24 months	24 (repeat)
F1	3	2	2	2	3		2	
F2	2		3		1		2	1
F3	3	1			1			
F4	1	1			1		1	
F5		1						

Key 0=not at all, 1=mildly, 2= moderately, 3= severely, 4= extremely

A weakness in the design layout of the questionnaire resulted in this box being left unintentionally unanswered. In addition the participants stated that they had difficulty remembering back over one month that meant this question was sometimes intentionally unanswered.

F1 was previously employed in a professional and demanding job but retained the capacity to identify how she has been impacted by illness. The answers are congruent with her ability to function.

F2 was previously employed as a professional and retains some ability to see how life has been impacted by illness.

At the baseline assessment F3 was learning how to cope with additional responsibilities as well as settling into the community. The subsequent scores reflect the adjustments being at the time.

F4, as a full time worker, has had to remain in control, but she described in the newcomers questionnaire that socialising and joining in the community life were very difficult, almost impossible at the time.

F5 was mostly unable to remember the previous month. But remained in full-time employment.

The main advantage of having such a small number of participants is the opportunity to analyse the data with respect to individual circumstances. This results in a richer understanding of what was happening for each participant that would be lost in a bigger, mathematical or statistical study.

5.4.5 Non-Outcome Measure Results

Other results at the time of writing (November 2011) that are significant in answering the question about the benefit of the community but not in terms of the chosen outcome measures are listed here.

- Employment - the two participants that were in employment at the start of the study remain so with one other in part-time employment. One participant is volunteering with a view to going back to work.
- Education - One participant is now in higher education and another has completed a return to work course, a third is taking evening classes.
- Health – there have been no further referrals to secondary care and no hospital admissions. No participants have started on medication and there have been no increases in medication. There have been improvements in

physical medical condition and beneficial weight loss. Medication reduction in one participant alone resulted in cost saving of between £2,116.20 up to £2,455.50 (depending on the 'as required' drug usage) year to NHS. One participant was discharged from secondary care psychiatric services.

- Benefits – reduction in housing benefit saving £ 2,400/ year to government.

5.4.6 Summary

The dissemblance demonstrated by the participants in the baseline assessments and disclosed at the six month assessments leads to the proposal that there had been a perceptual change in context. At the baseline assessments in using the diagnostic interview followed by the self-report measures had resulted in the participants viewing the researcher in a mental health role. However, the subsequent disclosure of dissemblance leads to the proposal that the context had perceptually changed and become less associated with mental health. This finding suggests that there had been contextual dissemblance.

The other reason given for dissemblance was lying from self-deception. This suggests that the participants were looking back over six months and proposing that they had been unable to answer the self-report measures accurately as they were unable to 'know themselves' at that time.

The results are inconclusive in terms of being able to demonstrate benefits from the outcome measures, because of the small sample size and also because of the complex dynamics of incongruence between outward presentation and inner distress and dissemblance. Another confounding factor was the fear and anxiety. For example, fear of being sectioned if discovered to be ill. However, one of the main results of this study is that this incongruity can be discovered by using different outcome measures that are observer and self-report. The results of the SCL-90-R, CGI and WHODAS-II are broadly correlational in terms of severity and fluctuation. The comparison between the PST and PSDI results suggest that the disclosed dissemblance may not have been as significant as first thought.

5.5 Qualitative Findings

Introduction

Chapter three presented Grounded Theory method and the way in which it is conducted including examples of coding and categorising. The chapter provided illustrations of how the categories were conceptualised through theoretical sampling to achieve saturation. The relationship between the categories and theoretical coding was also explained.

In this section the findings from the grounded theory analysis are presented. The process of how the theory emerged through the constant comparative method of coding, sampling and memoing gradually becoming more conceptual is described. This chapter presents the sub-core categories of pathogenic emotions, pathogenic relationships, losing self, salugenic relationships, salugenic emotions and finding more of self. Finally, the development of the core categories of incongruence and congruence and how these core categories integrate the data are presented. All interview data, questionnaire data, field notes, emails and memos are included as primary data. Substantive and theoretical codes and categories will be underlined to highlight their conceptual use in the theory. In this chapter the findings relate to female participants and therefore it is written using the terms 'her' and 'she'.

5.6 The Emergence of Pathogenic Emotions

This section describes the first part of the analysis that emerged from the categories starting with <u>fear</u>, <u>shame</u> and the consequences of <u>fears becoming a reality</u>. From analysing the relationships between the categories a pattern emerged of the type of emotion that is termed 'pathogenic'. The theories of emotion and the difficulty with defining emotion were introduced in chapter one. This resulted in the choice to focus on core characteristics of emotion as differentiated from cognition, which are emotional connectivity, expression, contagion and valence. These characteristics all have particular significance for this grounded theory. The definition of pathogenic followed by a definition of fear used in the present theory is presented first.

5.6.1 Defining Pathogenic

The term pathogenic is most often used within the context of infectious diseases such as viruses and bacteria, but in this thesis the term pathogenic is used as a broader definition of generating psychological and spiritual harm or sickness. The Latin root word *pathos,* meaning suffering or disease, could aptly apply to emotional and mental disorder. It is distinguished from pathological by proposing that pathological means an inherent property of harm as opposed to pathogenic meaning the potential to generate harm.

In this context 'pathogenic lifestyles' was used by Jourard (1971: p.71) to describe lifestyles that were harmful to an individual in terms of mental well-being and as previously stated (section 2.1.2) pathogenic is used by Clinebell (1984: p.110) to describe 'harmful religion'. The discussion of 'pathogenic religion' was continued by Seeber (2001) who defined pathogenic as 'sickness generating'. In discussing communities as an aetiological agent of addiction White (2004) defined pathogenic as 'wounding' or 'deforming'. Some authors have used it within the context of being harmful to health or sickness producing but without definition (Johnson, V. K. & Lieberman 2007; Lane 2008; Kukleta 2011). Others have clearly defining pathogenic as psychologically harmful or sickness inducing. For example, Tangney (1992) 'pathogenic guilt', Gilbert (2006) 'pathogenic guilt', Meehan et al (1996) 'pathogenic beliefs' in addiction. In research on posttraumatic growth Laufer, Solomon and Levine (2009) simply define pathogenic as negative outcomes from traumatic events. Lane (2006: p.116) has proposed that 'negative affect that is not experienced or expressed may be the most pathogenic response to environmental stress'.

Following on from these authors the definition of pathogenic used in this theory is as harm or sickness inducing/generating.

5.6.2 Defining Fear

The broad introduction to emotion was provided in chapter one. This section focuses on fear, which is a basic emotion defined as being pre-wired, lower pathway, independent of cognition and conscious thought. The neurological origin of this emotion can be found in the primitive brain structures of the brain stem and

amygdala. The physiological reaction to a threatening situation is to release adrenaline priming the body for a 'flight or fight' response.

There are two terms used in psychiatry to describe the fearful emotions these are anxiety and phobias. Anxiety is defined as the normal response to danger. Anxiety can become pathological when it is out of proportion to the actual or perceived threat of danger or when it persists beyond the threat of danger. Phobias are defined as irrational fears, for instance, fear of spiders or the fear of 'germs' (Gelder, Mayou & Cowen 2001: p.7).

'Fear or anxiety… is the felt insufficiency of one's own power (or an excess of the other's power)' (Rachman 1978: p.56). Fear has also been defined as 'fear…motivates and reinforces behavior that tends to avoid or prevent the recurrence of the pain-producing (unconditioned) stimulus' (Mowrer 1960: pp.48-9). LeDoux (1998: p.228) distinguishes between fear and anxiety as 'Anxiety is distinguished from fear by the lack of an external stimulus that elicits the reaction – anxiety comes from within us, fear from the outside world'.

Rachman (1978: p.4) suggested three components of fear;
- The subjective experience of apprehension
- The associated physiological changes
- Attempts to avoid or escape from certain situations.

However, these three components are rarely congruent as sometimes an outward calm appearance is not the same as the inner physiological reaction. These distinctions and dichotomies are found in the language used by the participants in the current study who often used complex language blurring the distinction between feelings, thoughts and actions. The majority of words that are used in these data are 'fear' and 'afraid' and the occasional use of the term 'anxious'.

The definition of the term fear used in this thesis is that of Mowrer's but includes Rachman's link to insufficient power. The inclusion of a reference to power will become salient in section 5.7.2 on pathogenic relationships.

The first categories to emerge from the open coding process were concerned with emotions and in particular with fear and shame. However, data demonstrate a difficulty with all emotion. The category of difficulty with emotion in presented first.

5.6.3 Difficulties with Emotions

Emotions were overwhelming, and something to be afraid of. <u>Fear of emotion</u> and <u>fear</u>, <u>shame</u> and <u>hopelessness</u> became a trap.

> *"… I never used to cry at all apart from when it got really, really stressful and it was ahh".* F4 text ref 10232,10752

> *"… so the last overdose I took was not intention to kill myself, I just wanted to stop feeling, I just wanted a break".* F2 text ref 32196,32316

> *"Not sure if I have been that honest because closed off the fear in living because I can't go there, so scores may be different. Just making life now".* F3 FN-71010-1

> *"I find it difficult to figure out how I feel. I notice indicators…"* F5 text ref 31560,31819

These difficulties are related in part to the <u>fear of emotion</u> that is connected to the <u>fear of madness</u> through the potential to 'lose the plot' demonstrated below.

5.6.4 Fear of Emotion

Fear of emotion emerged from the codes <u>fear of suddenly losing the plot</u> and <u>fear of exposure</u>.

> *"It has been a bit bizarre. It still worries me cos I know people lose the plot quite quickly don't they? You don't know when you are going to lose it".* F4 text ref 32927,33034

> *"Maybe it is a fear that actually if I looked, if I looked too much at what there is still to look at I would panic".* F1 text ref text ref 8942,9339

Fear emerged as a dominant process driver. The expressed panic and anxiety in the data underlies a psychological social process that was further explored through identifying patterns in the data relating to fear.

5.6.5 Fear

There were 87 indicators (or incidents) of <u>fear</u>. These <u>fear</u> codes were then grouped through selective coding into eight different secondary codes. These are not categories as they are not conceptually higher than the open coding, but codes formed in a two-stage process. Forming secondary fear codes gave confidence that the original meaning from the data was retained.

Each of these secondary codes was formed from grouping together primary codes. The secondary codes are listed and underlined below along side the primary codes.

<u>Fearing relationships</u> – fear of people, fear of connecting to people.
<u>Fearing exposure</u> – fear of feeling judged, fearing the consequences of disclosure.
<u>Fear of self</u> – fear of being wrong, fear of madness, fear of being called a fraud
<u>Fear of power and authority</u> – fear of authority, fear of being forcibly treated, fear of mental health services.
<u>Fearing rejection</u> – fear of not being believed, fear of not being helped.
<u>Fear of God stuff</u> – being denied choice, being denied the freedom to disagree, fear of god stuff.

Although <u>fearing change</u> is listed here it actually arises in a different context of <u>salugenic relationships</u> so will be discussed in the next chapter. Also <u>fearing God stuff</u> is a category that relates to <u>pathogenic relationships</u> rather than specifically to <u>pathogenic emotion</u> and therefore it will be discussed in section 5.7.2 below.

<u>Fear of power and authority</u>

The category of <u>fear</u> is related in the data to the object of fear, that is to say, people and mental health services. Most of these secondary codes could be grouped under fear of people as <u>fearing relationships</u>, <u>fearing exposure</u>, <u>fear of power and authority</u> and <u>fear of rejection</u> are all fears about others. In particular at this point there were significant references to health services. There were 31 indicators related to the <u>fear of being sectioned</u>, <u>fear of being taken to mental hospital</u> and <u>fear of authorities</u>.

<u>Fear of authorities</u>

> *'I was frightened of being locked up'.* E-00119-F5

Fear of being sectioned

> "…*not only was I worried probably that you lot would put me into hospital I probably thought that if I admitted to how bad I felt I would probably put myself in hospital*". F2 text ref 1903,2322

In the last extract above the <u>fear of being sectioned</u> was related to not wanting to admit how bad she was feeling. This extract from a conceptual memo demonstrates the researcher's thinking at this point

CM-00711-1 Preconceptions
Fear that the other person has power over them i.e. mental health services and the power to section, resulting in deprivation of liberty. The power to judge someone as mad and the results of that judgment.

Fear of exposure

The fears can be linked together in the data, such as, <u>fearing relationships,</u> which is related to <u>fear of exposure</u> because exposure implies a social context. <u>Fear of exposure</u> and <u>fear of power and authority</u> are linked by fearing that exposure will lead to being judged as 'mad' for which the consequences will be to be labelled, receive treatment from mental health professionals or even to be 'sectioned'.

The following data extract is the consequence of having unintentionally admitted to feeling depressed to a nurse who then suggested the general practioner may or may not prescribe anti-depressants.

> "…*once it gets outside, I mean when it's in your head it's bad enough, but then when one person knows its even worse, but then when people who are doctors,.. they find out, it is way more serious than when it is just in your head isn't it*". F4 text ref 23207,23479

This is an example of keeping the feelings of how bad she is feeling to herself because of fear of what will happen if she is honest with another person.

<u>Fearing exposure</u> intensifies the <u>fear of relationships</u> and of <u>power and authority</u> as there will be a felt need to withdraw and hide from others. The following extract further demonstrates the outcome for F4 of having been covertly assessed for depression by a practice nurse.

133

F4:   *"And I was like, oh my God you [the nurse] have planned these questions. This is not like a chat, would you like a cup of tea? How are you?"*

Researcher: *"Do you still trust her [nurse]?"*

F4:   *"Um, I don't know, I think so. I would go and know what was expected. I wouldn't be caught out again… I will be ready for them questions. And I know the chitchat is not chitchat. I know the chitchat is information gathering".* Text ref 23207,234479

<u>Fear of exposure</u> is related to having something to hide and what emerged specifically was fear of self-exposure. The fears about self include a specific belief that there is something fundamentally wrong.

Having found the codes relating to <u>fear of exposure</u> and <u>fear of authorities</u>, there is a relationship with the code of <u>fearing rejection</u>.

Fearing rejection

Fear of rejection is related to participants finding themselves in the health services and not being helped. <u>Fearing rejection</u> linked to previous codes of <u>fears of not being helped</u>, <u>fear of being discarded</u>, <u>fear of not being believed</u> and <u>fear of being called a fraud</u>.

> *"So I am kind of afraid of two extreme reactions each end of the thing. One end is that I will be ignored or discounted or said, well you are making a fuss over nothing".* F2 text ref 16949,17832

> *"So if they [doctors] make their judgement, they write it down, then that is that… It's that not being listened to or taken seriously or it felt like I was just a problem".* F2 text ref 28005,29211

These fears had an impact on behaviour that will be demonstrated next.

5.6.6 The Impact of Fear on Behaviour

Through the constant comparative process in the analysis the researcher identified that many of the fears expressed in the data had become a reality through their encounters with health professionals. This was categorised as <u>fears being realised</u>.

Fears being realised

Prior-held fears of health professionals and people with power and authority mean that not being helped, being wrong, feeling judged, become a reality in the encounters with health professionals and others in authority. This section conceptualises the process that occurs when five of the fear codes, fears of relationships, fearing exposure, fear of self, fear of power and authority and fearing rejection, have become a reality.

The category of fears realised was formed from the extensive list of fear codes and the categories of not being heard was grouped from the following codes, feels falsely accused, perception of being the enemy to the services. An example of this is given through an experience of being in a mental hospital and having not felt she was not given the time to say what she wanted to say.

Feeling what she wants to say is worthless.

> *"… and your time when you speak to the doctor…in hospital, theoretically you get to go to a ward round which is 8 professionals sitting in a room. If you have a lot of anxiety anyway, and they go and ask you something what do you say? I used to refuse to go in".* F2 text ref 5712,6295

These two categories of fears being realised and not being listened to are linked in the data. In one way not being listened to could also be categorised as a fear through the code fear of not being helped. But instead it is kept as a separate category in order to preserve the importance of 'being listened to' for the participants. This pattern will emerge throughout the development of the grounded theory. The analysis demonstrates that the feeling or perception of not being heard intensified the fear of not being helped and at the same time intensified fear of authority. This situation gives rise to a barrier between the person and health professional that becomes detrimental to further help-seeking.

In the next section the category of feeling shame and how it relates to fear in the data and the emergence of pathogenic emotions is demonstrated. This is preceded by an introduction to shame and the definition of shame used in the present theory.

5.6.7 Defining Shame

The self-conscious emotions are defined as shame, guilt, humiliation, embarrassment, pride and hubris. These emotions often occur together and the distinctions can become blurred. Therefore Helen Lewis treats other descriptions of shame, such as chagrin, humiliation and shyness, as variants. However, others have distinguished between them (Lewis, M. 1992; Meehan et al. 1996; Gilbert 1997; Dearing, Stuewig & Tangney 2005).

Shame is what 'I' have done to myself and humiliation is what 'they' have done to me. Humiliation results in feeling of indignation, anger or revenge towards the humiliator but is not necessarily shame inducing (Lee, Scragg & Turner 2001). Humiliation is the what is done to a person and therefore the focus is on the perpetrator not wholly on the self (Gilbert 1997). Shame may result from being humiliated, but humiliation does not always result in being shamed unless 'they have violated their own code of honour' (*ibid*).

Shame is often found along with guilt, but they can be distinguished from each other by defining guilt as the recognition that an action or behaviour related to a specific event was negative as opposed to shame in which the global self is the focus of negative judgement (Lewis, H. B. 1971; Meehan et al. 1996). Guilt leads to reparation for the damage or hurt done. This is important in the area of research into criminal behaviour where shame, is more likely to become pathogenic than guilt (Stuewig et al. 2010). Michael Lewis (2003) distinguishes between shame as a 'global attribution' and guilt as a 'specific attribution'.

Embarrassment is distinct from shame in intensity of body reaction and by the trigger, which is defined as conspicuousness rather than transgressional exposure found with shame (Lewis, M. & Ramsay 2002). It is limited to a 'moment' in a public arena and therefore related to a public self (Tracy & Robins 2004).

Development of shame

Developmental child psychologists and neuroscientists have determined that shame develops alongside the development of self-awareness (Feiring 2005; Lewis, M. 1992; Schore, J. R. & Schore 2008; Schore, A. N. 2009a). Studies were conducted with babies and infants to determine at what age they are able to

recognise themselves in a mirror. The findings show that this typically occurs around the age of two and that along with this self-awareness the self-conscious emotions being to develop. The child development psychologist, Michael Lewis (1992: p.58) proposes that the emotion of shame can develop by the age of two but the objective self-awareness of shame develops later at the age of three.

Definitions of shame

For Helen Lewis (1971: p.39) shame originates in the self, in our thoughts about ourselves and is the reflection of and drawing inferences about how a significant 'other' thinks of us. Shame can become an 'intrapersonal trap' where the person becomes ashamed of feeling shame (*ibid*: p.37). She defines shame as an emotion of the whole self and is particularly painful because shame involves proprioreceptors and kinaesthetic feedback that heighten the intensity and painfulness of the affective experience (*ibid*: p.39). She also identified three different types of shame experience: 'overt shame', 'overt, unidentified' and 'by-passed' shame. Overt shame is recognised by body language and lowering of the voice suggestive of the person being consciously aware of feeling shame. In overt, undifferentiated shame the person is aware of a physiological/emotional reaction, but either cannot or will not recognise it as shame. They may label their reaction as something else or be confused or blank about its meaning. By-passed shame is not consciously felt instead there is a cognitive 'jolt' or disturbance that may cause the person to have doubts about their self-image in the eyes of the other (*ibid*: p.197). Lewis (1971: p.15) identified that shame was particularly contagious as it encourages hiding, therefore an observer of another person's shame will turn away from it in shame.

A psychological definition of shame is a discrepancy between the 'ideal' and 'actual' self. The psychological importance of shame was stated by Michael Lewis (1992: p.2) as 'to understand shame is to understand human nature' and he defines shame as 'the feeling we have when we evaluate our actions, feelings, or behaviour, and conclude that we have done wrong'. He also writes shame is the self focusing on self's failure, 'and the evaluation of that failure that leads to shame and not some automatic elicitor' (2003: p.1186). He goes on to write that shame results from a global attribution 'because the valuation of the self by the self is total. There is no way out' (*ibid*: p.1199).

Shame has been defined as 'toxic unwantedness' (Pattison 2000: p.182). Pattison (2000: pp.83-4) identifies three different types of shame, two of which he calls 'disgrace shame' and the other is 'respect shame'. Disgrace shame can be acute and reactive, and is typified by being momentary and short-lived, whereas chronic shame can shape a personality and be present throughout a lifetime. Chronic shame is found in those persons who are 'shame-prone'. These are differentiated from 'respect shame', which is derived from the meaning of the phrase 'has no sense of shame'. It refers to a sense of respect for a person, institution, values and behaviours.

Sociological

For Helen Lewis (1971) and Scheff (2000) shame signals a threat to the 'social bond'. This can be viewed as a positive aspect of shame. For Scheff (2000) shame is *the* social emotion. The degree of shame felt can depend on the perceived significance of the relationship in danger. The appearance of shame signals to the 'shamer' that they have threatened the social bond.

Phenomenology of Shame

The perceived difficulty in identifying specific facial expressions of shame singled it out as unique (Tracy & Robins 2004). However, there is consensus that expressions of shame involve the whole body. Shame feels as though the whole of one's self is involved and available for global scrutiny (Pattison 2000: p.73). Shame is characterised by avoiding eye contact, looking downwards or away, and slumped body. It is also experienced as 'wordless', instead images of how the 'other' perceives the person predominate (Lewis, H. B. 1971: p.37). This wordlessness contributes to non-recognition of shame.

Shame is associated with a sense of shrinking, of being small, and worthlessness and powerlessness (Tangney, Wagner & Gramzow 1992). The authors go on to say that shame involves the look of a disapproving other, but that even when 'alone the disapproving self imagines how the self might look to another person' (*ibid*: p.469). Thus it involves the capacity to be able to self-reflect.

Shame is a particularly painful emotion associated with rejection and fear of rejection (Eisenberger, Lieberman & Williams 2003; Kross et al. 2011) and with

feelings of helplessness (Budden 2009) powerlessness and loss of control (Lindsay-Hart 1984). Shame is more self-conscious than guilt and carries with it a sense of being exposed to the judgmental eye's of others. Shame impacts the concept of the self as being flawed, bad, and wrong especially in comparison to others (Lee, Scragg & Turner 2001). Shame is experienced as an assault on the self and self-concept and damages relationships with others (Van Vliet 2008). The experience of shame can be summed up as;

- resulting in the desire to hide or disappear,
- intense pain, discomfort and anger,
- feeling the one is no good, inadequate unworthy
- a fusion of subject and object as the self focuses in the self and results in confusion, the inability to think clearly, inability to talk and inability to act (Lewis, M. 2003).

The totality of these effects on the person is described as 'the shrunken self' (Lindsay-Hart 1984).

Positive shame

Self-conscious emotions have a positive role in self-regulatory behaviour (Beer et al. 2003; Beer & Keltner 2004; Leary 2007). Lindsay-Hartz (1984) suggests two positive roles of shame. Firstly, through becoming aware of who we do not want to be, shame supports the positive ideals about who we want to be and can promote positive change. Secondly, shame serves to reinforce the importance of social determination of reality. In defining shame and guilt as moral emotions it is proposed that these emotions serve a purpose in determining moral behaviour (Tangney, Stuewig & Mashek 2007; Tangney, Stuewig & Hafez 2011). Shame is a defensive demarcator between self and others in the relationship (Pattison 2000: p.79). Shame is described as a 'soul mask' or 'fig leaf' to cover up the exposed self in order to survive the rupture in a relationship (Jacoby 1994). Shame can be seen as a guardian of the self and an internalised means of self-control.

Summary

Shame is a self-conscious emotion that depends upon objective self-awareness. It involves thinking about self in the mind of others and is dependent on the ability to self-reflect in this respect it can be regarded as a social emotion. It is contagious and can become an intrapersonal trap where the person feels ashamed that they are ashamed. It is often unacknowledged as it is particularly painful. Shame may

be observed from body language and from narrative where expressions of worthlessness, helplessness and feelings of being flawed or bad may predominate.

5.6.8 Feeling Shame

The coding of <u>feeling shame</u> might be seen as an oxymoron given that most of the indicators of shame refer to 'by-passed shame'. However, this decision is justified by referring back to section 2.4 where feeling is the term used to describe the mental experience of an emotion but it can be non-conscious (Damasio 2000: p.37). A feeling has to become conscious for the 'feeler' to 'know' that they are feeling (Lane 2006). In the present study these data are limited to narrative expressions of shame and do not include data on body language. The category of <u>feeling shame</u> was developed from Helen Lewis' concepts of overt, overt undifferentiated and by-passed shame by identifying key words or phrases in these data. For example, stupid, foolish, inadequate, lacking self-esteem, exposed, vulnerable, and 'by-passed shame' by rapid, repetitive negative self-evaluation that was obsessive in nature (Lewis, H. B. 1971: p.197). Using Lewis' proposal one participant was identified as having 'by-passed shame' through the use of rapid and repetitive speech. However, the language of negative self-evaluation is similar in all the participants and therefore a distinction has not been made. The proposal is that the data reflects mostly 'overt, undifferentiated shame' with two indicators of overt shame:

Overt Shame

> *"So subliminally it suits me that you have made this false assumption…And I was quite horrified and I thought, that has arisen out of…partly a shame thing. I don't want you to know all of this".* F1 text ref 37582,37760

> *"[Before moving to Deal] I was actually at home in my room; I had that many thoughts in my head all the time especially at one point. I think actually a lot of it goes to shame and stuff like that. So to stop me thinking over stuff and getting really upset, I would watch TV so there was always a noise in my head".* F5 text ref 21952,22550

Overt, undifferentiated shame

Apart from the two overt incidents of <u>feeling shame</u> above, 69 indicators relate to overt, undifferentiated shame. In these data the category <u>feeling shame</u> emerged from the codes related to expressions of <u>fearing exposure</u> and <u>fear of rejection</u> (see above in section 5.6.5), self-worth issues and <u>self-judgement</u>. For instance, the participants express the feeling that they are the 'problem'.

<u>Feel worthless blamed and essentially flawed</u>.

> *"Because I had got to the point of thinking I was making it all up and particularly because the consultant here was like there is nothing really wrong with you".* F2 text ref 961,1421

> *"And nobody seems to understand that that makes a big difference and it feels like they blame me for saying why is this not working the only problem can be you. And I think I have taken it on that the problem was me".* F4 text ref 5251,5468

<u>Self-judgement</u>

> *"I think as well that my sense that everything was somehow all my fault was very great then. So it was all like, I couldn't give myself any understanding".* F1 text ref 3153,4284

> *"And we all know that I was a huge failure".* F1 text ref 28907,28949

> *"If I am too much of a bother then she will go, "do you know what I haven't got time for you" ".* F4 text ref 35617,35987

In another incident one participant felt shamed by having her faith mocked:

<u>Mocking of faith</u>

> *"…she ridiculed my faith and said I was just waiting for an omnipotent figure to rescue me and she said that was ridiculous and she said that was a dissembled responsibility".* F2 text ref 23115,23762

The data demonstrates that participants felt <u>powerless</u> and <u>worthless</u> in situations.

> *"So it leaves you with nowhere to go and also what I have got to say is worthless".* F2 text ref 9482,10406

<u>Risking disclosure resulted in not being heard</u>

> *"Pretty crap,.. it's that not being listened to or taken seriously or it felt like I was just a problem. So for example, if I was feeling more suicidal and I tried to talk about it to them, the reaction I got was I was just trying to make their life difficult and they said things like if you want to kill yourself you will so you don't need to tell us about it. So it's kind of, what's the point, really?"* F2 text ref 5282,5698

<u>Feeling judged</u>

They were not able to say what they wanted to say and were not offered opportunities to discuss treatments.

> *"And also you feel quite powerless, so if they make their judgement, they write it down, then that is that".* F2 text ref 4981,5235

Shame leads to <u>isolation</u> and withdrawal from others

> *"I can't go "can you help me?", that doesn't really come out of my mouth so, couldn't really do anything, I felt I couldn't do anything about my situation".* F4 text ref 13602,13753

5.6.9 Development of Trapped Emotions

The process that emerges from encounters in the data is that of how fears and shame become a reality. When those emotions are not faced or challenged, a process emerges that could become detrimental to seeking and receiving help.

There are five conditions in which emotions become trapped.

- Lack of self-awareness identified (section 5.6.3) in which the participants were not aware of how bad they really felt.
- For other participants their emotions were overwhelming but did not have a way out so had to learn to cope (section 5.6.3)
- Fear (section 5.6.5) of authorities and sectioning prevents being honest with professionals and prevents help-seeking.
- Shame is hidden (section 5.6.8) as indicated by the language used in the data. This hidden shame drives the need to withdraw and isolate from others and from self to avoid the pain of shame.

- Powerlessness and hopelessness linked to shame leads to a sense of not being able and not knowing how to change.

The fears listed above become a trap, for example, <u>fear of exposure</u>, <u>fear of not being believed,</u> <u>loss of hope in system</u> and <u>hopelessness of unchanging situation</u> when combined are a powerful reason not to communicate.

> *'It is overwhelming to admit to something that you truthfully don't know the way out of, to do that would make you look at it and then feel despair'.* E-10120-F3

Those that do not find a way out become trapped by their emotions. Shame and fear drive a process of <u>loss of trust</u> towards <u>isolation</u>.

CM-20420 Pathogenic emotions theoretical code

The emotions identified in this theory are, shame, fear, hopelessness, worthlessness and powerlessness. These were grouped into this category as it was expressed as a feeling in the data. There were probably many other emotions present but these were not expressed in the data. This theory describes the process by which unrecognised emotions, predominately fear and shame, that are actually rational and normal (good), become a trap for the self (bad). The consequences of being trapped are isolation and intensification of the emotions that lead to hopelessness. Without a way out the self continues in this state of engulfment or acceptance, that is to say, the emotions have become pathogenic. Conceptually the category of <u>Feeling trapped by fear, shame and hopelessness</u> became <u>pathogenic emotions</u>.

Summary

It is in this trapped state that emotions become pathogenic, as they are no longer serving a useful purpose in providing an impulse to act. The opposite seems to be occurring where very little is changing and the person is trapped. <u>Pathogenic emotion</u> is emotion that is hidden, not acknowledged, denied, and also at times overwhelming. Applying the focus on the characteristics of emotion as connective, valenced, expressed and contagious, <u>pathogenic emotion</u> is not expressed, not connected to self or others and predominantly negatively valenced. They drive behaviours such as one participant using television as noise to stop her thinking

about shame, refusal to speak to professionals, not wanting to be a bother, taking an overdose, and difficulties with relationships and a low, negative opinion about self. The next section demonstrates how pathogenic emotions relate to the difficulties with those relationships.

There were no primary data related to contagion and pathogenic emotions. Although both Rachman and Helen Lewis note that fear and shame respectively are contagious.

5.7 The Emergence of Pathogenic Relationships

In this section the concept of pathogenic relationships, including their properties and consequences, and their relationship to pathogenic emotions is presented. The emergence of pathogenic relationships from the category of power relationships is described. Pathogenic relationship is defined as a relationship that has the potential to generate or induce harm or adversely affects health to one or both parties in terms of mental, emotional, physical and spiritual health.

5.7.1 The Properties of Pathogenic Relationships

In the previous section categories relating to the realisation of fear in relationships, through feeling there was no one listening and no one to help, led to pathogenic emotion and loss of trust. Pathogenicity relates to the consequences of the interplay of these concepts on the self as feeling judged, feeling the enemy to them, shame, loss of trust, powerlessness, and worthlessness. The consequences are harmful to the self in terms of preventing help-seeking and believing they are not able to change. The properties of pathogenic relationships involve, unequal power, judgments and loss of trust.

5.7.2 Unequal Power

One of the categories that emerged early on in the analysis was power relationships. The definition of power as used in this theory will be presented next.

Defining Power

Power has been described in terms of winning and losing (Kemper 1978). In his extensive exploration of emotions Kemper (*ibid* p.26) sets out a position derived

from a number of studies that suggest that 'social relationships can be understood as a reflection of two dimensions of interaction content, power and status'. Power as either winning or losing is relevant to this section of the theory where pathogenic relationships are characterised by 'war'. Power and status are recurring themes in the analysis where pathogenic relationships are characterised by one party having or perceived to have greater status and power than the other. In mental health, the stigmatisation of the mentally ill results in a perceived lower status.

In the present theory power is defined as, the energy or capacity to bring about change or make something happen. Using this definition it is possible to see that power can be used positively or negatively depending on how the change is brought about and the nature of that change. For instance, using coercion to force a person to do something they do not want to do devalues and demeans that person. Power used positively, for example, by giving the person knowledge in order for them to bring about positive change results in empowering and dignity.

These were relationships with the property of <u>unequal power</u>, where one person has power over another.

> *"...then one psychotherapist told me that I made her depressed. [The psychotherapist said] She walked into the room quite happily and she started talking to me and I sucked her dry and caused her to be depressed. So which is quite a powerful statement".* F2 text ref 16119,16823

<u>Power relationships</u> can be demonstrated in the context of health care where there is perceived <u>collusion between professionals</u> that causes a <u>lack of trust</u> and fuels the perception of <u>unequal power</u> in the relationship.

> *"… I think as a patient you feel quite powerless. So if one doctor tells a nurse and nurse tells so and so. The professionals listen to each other; they don't listen to you as a client".* F2 text ref 5712,6994

This creates a disjuncture that harms the formation of rapport leading to a patient or client that <u>intentionally withholds information</u> in order to keep <u>control</u> of the situation. Control over information or knowledge is an attempt to redress the

balance of power. In addition the patient/client perceives that the health professional did not want to really get to know them. This intensifies pathogenic emotion.

> **CM-00623 The abuse of knowledge in power relationships**
>
> As a child F4 was diagnosed with a medical condition but the knowledge about the illness is given to her parents who do not teach their daughter. She is left feeling out of control. She is therefore reliant on her parents and as an independent adult she does not possess all the information to make choices about her treatment or even her lifestyle.
>
> As an adult F4 realises that if she gives the professionals information in the form of a psychiatric measure, she gives them knowledge about her. She does not trust them with that knowledge as they may put her on medication or her worst fear may be realised and they would section her and forcibly treat her.
>
> In both instances the power rests with those with the knowledge. Deny them the knowledge and she maintains a degree of control over herself.
>
> For F1 power is in the hands of the agencies responsible for her health and benefits. They have the knowledge about her and her illness. The extent to which she perceives they have power means that she is in fear of them and their capacity to turn against her producing a terror that she feels she will die.

The inequality in power can be conceptualised as being at 'war', coded as perceiving judgment from professionals.

> *"Most mental health professionals, not just me but treat you as a kind of enemy really".* F2 text ref 36609,36809

In these data professionals conclude they have the knowledge they require to treat a person but this can leave the person feeling as though they have not been talked to.

> *"[In the] mental state exam, they ask you to do things like count going from 100 subtracting 7 going backwards, which I don't think I could do with two people*

146

watching me even when I am not depressed. And I got a bit stuck in it and lost in it and they just sit there looking at you, hell". F2 text ref 1936,2436

As seen above <u>unequal power</u> also resides in parent child relationships. Parents have knowledge that is not communicated to the child as she grows up leaving the adult powerless to make decisions about her medical condition.

CM-00707-1 You don't really know me (and I am not sure I want you to)

Data points towards a situation that occurs when faced with a <u>power relationship</u> that generates a <u>them and us</u> situation, whereby something is perceived to go wrong in that relationship and the person involved decides that the professional does not really want to know them.

For F4 it was a long history of never having been told the whole story of the medical condition. Not being able to reveal the truth of how they were feeling.

F2 it was the clumsy approach of the admitting doctor in not picking up on humour cues and other cues given by the person resulting in her shutting down "If you don't ask me then I am not going to tell you".

F1 data suggest that it is her work status that has prevented her from allowing professionals to really know her fully.

F3 interestingly is the result of insight "I don't really know myself yet", so that means that you won't know me either.

Fearing church authority

One participant used this <u>fear of 'God stuff'</u> term as a descriptor meaning everything connected with church and God.

> *"…then the [a Christian organisation] said they felt the Lord was saying that it was time for me to move out, it wasn't a good place for me to be. …and so I moved out of …, as I clearly wasn't getting anywhere with the mental health services I would look at different things. And most of them were bit too mad Christiany things so I kind of put them together and put them in the bin".* F2 text ref 25064,27523

"it's only when you are required to do something you don't want to do. I know in my old house group they wanted me to pick songs and I absolutely point blank refused to do it and they were so shocked because they were "we would never know you were like that". 'Cos I didn't want to pick the wrong songs so I wouldn't do it...[It] caused a huge palaver". F4 text ref 21924,22401

The identification of the category <u>Fear of 'God stuff'</u> has important implications for the discussion of religion and spirituality in mental health. <u>Fear of 'God stuff'</u> is linked to <u>being denied choice</u>, <u>being denied freedom to disagree</u>, <u>hopelessness in an unchanging situation</u>, <u>loss of hope in church</u>. In the first extract the church used the authority of the name of God to suggest F2 should leave the organisation may have contributed to her <u>fear of God stuff</u>. In the second extract the shock reaction to F4 not picking songs led to a lack of mutual understanding.

5.7.3 Feeling Judged

Testing in the form of assessments and the use of rating scales or outcome measures can be seen as a <u>judgment</u> even though the use of outcome measures is not wrong in itself. However, it is the relationship involved in testing that is the key to the outcome. The use of assessments and outcome measures was perceived to be testing.

"Being tested. Like, when you are put in a psych ward there's all these points. it is quite hospitalised. Wasn't very human. Do you know what I mean though, connectivity?" F5 text ref 32702,33517

Previous encounters with health professionals, not solely mental health professionals, which involved the use of set questions and assessments were perceived as 'being tested' F5 text ref 32198,32551. In this study the use of the Mini International Neuropsychiatric Interview (M.I.N.I.) diagnostic interview and the outcome measures intensified the perception of 'being tested', which was demonstrated with the reactions to the baseline assessment. This is linked to the <u>fear</u> category through <u>fear of being judged</u>, <u>fear of authority</u> and/or <u>fear of mental health services</u> (see Section 5.6.5).

"And so what I felt able to disclose, so I think the help that they could give me was limited to what I felt able to say and by their perceptions". F1 text ref 6341,6487

In addition to being tested professionals can be perceived as making judgments about the whole person.

"She said she didn't think I could change and if I was to change a little bit it would take an awful lot of effort". F2 text ref 9482,10406

Within mental health this means that the patient/client, their identity, who they are or have become, is being tested and judged as either 'normal' or 'mad'. The results of testing then determine whether or not their fears are going to be realised of being 'sectioned' or of being taken to hospital.

In addition these judgments are not always made overtly but can be made covertly by being caught out. For example, the practice nurse who covertly assessed F4 (section 5.6.5). Covert assessment can have long lasting negative consequences on trust between professional and patient. This reinforces the power relationship as a power imbalance that results in a barrier to the therapeutic relationship where one side feels worthless.

"Makes me feel shit really, bit worthless and also like, it feels like they put all the blame on me that I am essentially flawed. So therefore there is nothing they can do to help, but it has kind of made me lose any trust in them at all. And it is also a bit hopeless". F2 text ref 8918,9468

In mental health assessments the nature of questioning can be personal and intimate and the potential for judgment is greater and the results more damaging. The divide between professional and patient can occur through the limitations in diagnostic boundaries in mental health as opposed to tangible medical tests such as some blood tests or X-Rays. For F2 explaining about a pervious assessment:

*"So, that was the most in-depth one and that was not that in-depth and after that they kind of **assume they know you**. So they don't ask you any other questions, like about everything".* F2 text ref 4362,4546

The phrase *"assume they know you"* illustrates the perception that professionals only obtain enough information to make a diagnosis. This could occur where there are categories and frameworks in which to put people. Using diagnostic categories gives permission to gather enough detail to make a diagnosis but at the same time ignore listening to the whole person. When the person does not feel listened too, they <u>feel judged</u> and <u>worthless</u>.

5.7.4 Loss of Trust

<u>Loss of trust</u> fuels the <u>fear</u> of not getting help. For one participant who was a mental health professional, becoming a mental health patient resulted in added shame and loss of dignity from her experience. Feelings of <u>powerlessness</u> and <u>worthlessness</u> fuel the <u>fear of authority</u>. This in turn fuels the <u>loss of trust</u>.

> *"[I] have been told by the doctor here "there is nothing wrong with you, pull yourself together. And told go to a pub and find yourself a man and have babies"... But it has kind of made me lose any trust in them at all".* F2 text ref 8921,9468

In addition to these data a key finding was the lack of trust the participants had towards the researcher exhibited by the dissembling with the baseline assessments. The reasons given for dissembling were;

<u>Loss of Trust</u>

> *"I was probably as honest as I can be, but there was still an element of holding back [from] …it is a little bit with me, but more with you".* F2 text ref 7057,7249

<u>Fear of being sectioned</u>

> *'First time [I completed the forms] I was frightened of being locked up'* E10118-F5

<u>Self-deception</u>

> *"I'm lying on half of these, 'cos I am sure I feel fearful most of the time, but you get used to it".* F3 text ref 20,48

<u>Fear of authorities</u>

> *"I know that here has… the women's pastoral and I know there are certain people that.., you get like a red flag, this is the way it works in my head, it probably doesn't even work like this at all. People who are on the radar, off the radar and I worry*

about being on the radar.., I don't know whether they would do anything but I worry that they would. Something would happen. I try not to be on the radar". F4 text ref 34284,34731

These data demonstrate the different motivations for dissembling with the outcome measures. Three of the participants specifically stated that they were afraid that the researcher would section them or have them sectioned. Another wanted to prove her own sense of failure. In addition others demonstrate the ability to reflect and admit that apart from fear they were unaware of how they actually viewed themselves at the time. This finding revealed more data that for all the participants there was a history related to mental health services and mental health questionnaires that was explored further in the interviews. This finding suggests that the researcher's professional role as a mental health professional and roles in Christ Church as a more experienced member and member of the Risk Management team had negatively impacted the participant's trust. This had in turn negatively impacted the responses in the baseline assessments. These particular data supported other data regarding their previous experiences with other health professionals and were conceptualised as <u>power relationships</u>. Lying and concealing will be discussed in the section on <u>deception</u> below.

5.7.5 Power Relationships Becomes Pathogenic Relationships

So far a one-sided conceptualisation through the category <u>power relationships</u> had emerged that did not fully integrate the data. This category had not taken into account <u>pathogenic emotions</u> or <u>loss of trust</u>. Focusing on <u>unequal power</u> produced a theory that seemed to be leading to a conclusion that one party was the cause of the problem and not the other. Integrating the categories of <u>pathogenic emotion</u> and <u>loss of trust</u> allowed a balanced theory to emerge.

Other data indicate another condition in the process illustrated by the code <u>explaining difficulty with paid staff</u>.

"I would like to say no, but it probably would, yea. Just 'cos then it is difficult to know whether you actually want to be doing it or it is just because you are paid to do it, then you go away and you are not part of it". F2 text ref 13167,123389

F2 indicates that having paid staff in Christ Church would be a problem for her that would result in her judging 'staff' as not really wanting to help her. The paid element could be perceived as a barrier in establishing a rapport.

In integrating these categories <u>power relationships</u> becomes a sub-core category of <u>pathogenic relationships</u> that arise in situations of actual or perceived power inequality occurring in the context of the researcher, church, parents and medical profession. They also include properties of reinforcing <u>pathogenic emotions, judgement</u> and <u>loss of trust</u>. <u>Pathogenic fear</u> and <u>shame</u> may have already been present before encountering professionals. Therefore it is incorrect to conclude that the relationships in these data were solely the cause of pathogenic emotion.

In the next section the ways in which participants learned to cope with the conditions of <u>pathogenic emotions</u> and <u>pathogenic relationships</u> through using a <u>survival strategy</u> are presented.

5.7.6 Theoretical Code Survival Strategy

In the context of the mental health services one might expect a patient to disengage from the services at this point. However, this is not evident from the data. A pattern emerged from five categories, <u>deceiving</u>, <u>manipulating</u>, <u>blaming</u>, <u>capitulating</u> and <u>performing</u> that seek to reduce the intensity of the fear and shame. A theoretical code with explanatory power was needed to integrate this pattern and was found in a theoretical coding family named strategy (Glaser 2005). This family included processes such as manipulating, deceiving and controlling similar to the categories in the present study. The theoretical code in the present study is named <u>survival strategy</u>, which is defined as an attempt to regain control in order to redress the balance of power in a <u>pathogenic relationship</u> in order to minimise fear and shame and protect the self.

The emergence of the theoretical code <u>survival strategy</u> in integrating these data is presented. In many respects the categories overlap with each other making individual discussion difficult. The participants demonstrated using one or more of them but not all. It is not possible to say from these data whether all the participants would use all the components at some point in their lives or whether some categories were preferred. This would require further research.

5.7.7 Deceiving Self and Others

As described above in section 3.1.5 all participants disclosed that for different reasons they had used some form of deception when completing the baseline assessments. In this section the conceptualisation of <u>deception</u> within the <u>survival strategy</u> is presented.

<u>Deceiving</u> others is part of the strategy to maintain control of <u>pathogenic relationships</u> that provoke <u>shame</u>, <u>fear</u> and <u>hopelessness</u>. The word deception is used as an overarching term that includes, <u>deceiving others</u>, <u>self-deception</u>, <u>intentional withholding of truth</u> and <u>intentional lying</u>. The use of deception is a consequence of shame and fears about being sectioned and being in hospital.

There were 29 indicators related to deceiving. The category of <u>deceiving</u> was developed from the codes <u>intentional lying in interview</u>, <u>intentional withholding of truth</u>, <u>understanding of how to play along</u> and <u>dichotomy between speech and feelings</u>.

> *'When you are ill it is like a fight for your life and you don't really have the luxury of relaxing into totally honest answers, I guess that is part of being sick'*. E-10118-1F3

Survival was considered to be the highest priority and not honesty.

> *"Not sure if I have been that honest because closed off the fear in living because I can't go there"*. FN-71010-1

It can perhaps be best summed up by

> *"…what is truth, when is misrepresentation actually fine because it is in the greater interest and when is it untruth".* F1 text ref 758,1171

This statement illustrates that one motivation for <u>deceiving</u> is 'the greater interest' of self-protection.

<u>Deceiving</u> others is an attempt to protect the self from vulnerability to others by concealing the truth out of fear and shame of the consequences of revealing the truth. The <u>survival strategy</u> that develops as a consequence of feeling trapped by

153

pathogenic emotion and pathogenic relationships is to maintain the divide between self and other to prevent an open relationship.

For instance by lack of self-awareness

> " 'cos, I am sure I feel fearful most of the time, but you get used to it". F3 text ref 61,134

> "I had no perception of how things really were. I think I would go everything is fine and I just want to sort out my two [issues] things that I came with". F4 text ref 17908,18002

Deceiving is closely related to performing, however the two categories are kept distinct from each other as deceiving is related to an intention to present untruths in order to mislead.

5.7.8 Performing

Performing is not necessarily a deliberate attempt to lie, although in some respects it is overlaps with lying, but performing may involve a chosen unreality and a carefully chosen presentation of self. There were 22 indicators related to performing. This category was developed from codes such as presentation of self as performance, carefully chosen degree of honesty, understanding of how to play along, choosing unreality. Instead of outright lying performance describes the ability to present the self in a more favorable light but can also imply self-deception through choosing unreality.

Performance, which is closely related to deceiving, is illustrated by one participant's experience of cognitive behavioural therapy (CBT):

> "I would appear to be smiling at times when actually I was completely disorientated and quite often with these health professionals they would be amazed at what they saw as my rapid progress... It wasn't progress at all …I would manage to crack what I was being asked to do. ..but I wasn't reaching [pointing inside her chest]". F1 text ref 8195,8787

Although there are no details of what kind of CBT or how many sessions were offered, the participant was able to either develop or continue to use her own defences to avoid engaging with emotional issues. In other words, the participant has to <u>learn hoops</u> (which is interpreted as the phrase 'jumping through hoops') in reference to CBT.

> *"But it was like learning hoops…because I was so split I would be able to do that at this quite superficial level so they would be very impressed".* F1 text ref 7721,8155

5.7.9 Manipulating and Controlling

<u>Manipulating and controlling</u> overlaps with <u>performing</u>, as it is a chosen strategy to keep control and power. There were 16 indicators related to <u>manipulating and controlling</u>. This category was formed from grouping together codes such as, <u>exerting control</u>, <u>manipulating the system</u>, <u>understanding of how to play along</u>, <u>categorising herself and others</u> and <u>looking for someone to collude with self-deception</u>. One of the ways in which manipulation occurs is by means of <u>intentionally withholding the truth</u>, concealing information which Goffman (1963: pp.108&122) terms 'control of identity information', this is done by withdrawing from self and people around in order to maintain the façade.

> *"If she doesn't expect anything then it is easy for me to go, go on, let's do it now. But if I knew she wanted me to do it now then I wouldn't be able to do it".* F4 text ref 36185,36532

> *"I said could you guarantee you wouldn't section me and she said I can't make any promises and that, not finished me off, but made me think right I have to be very, very careful".* F4 text ref 31490,31808

<u>Manipulating</u> the system develops as an attempt to 'get what you want', by saying one thing and doing another or saying something in order to obtain an appropriate response.

> *" "You know you are playing the system, you are just doing this so we'll do that", so I can't see the point really".* F2 text ref 36609,36809

Manipulating overlaps with blaming as a way of making the other person responsible rather than accepting personal responsibility.

5.7.10 Blaming

An alternative way to take back control is to blame the other for the difficulties and problems. There were 8 indicators related to blaming. This category was formed out of the following codes, blames doctor for problems, my needs are not being met, feels only been asked what staff want to hear, refusal to comply with ward routine, blames one person for not being able to trust community that all demonstrate the problem lies with the other person for not helping them. It is a way of not having to take personal responsibility for the difficulties or problems. Blaming others removes the focus away from self also creates a divide between self and others.

> *'It is harder work to form relationships with other people who are more sick than me'.* NQF441

5.7.11 Capitulation

The Oxford dictionary definition of capitulation is to 'give in to an opponent or an unwelcome demand' (*Compact Oxford English Dictionary for Students* 2006: p.140).

There were 26 indicators related to capitulation. The codes, perceiving judgement from professionals, resigned to the situation, impossibility of situation, believing that positive change was impossible or too hard, accepting illness equals hopelessness, not knowing how to be helped were grouped together to form the category capitulation.

> *"so,[I] couldn't really do anything, I felt I couldn't do anything about my situation".* F4 text ref 13602,13753

> *"Because I had got to the point of thinking I was making it all up and particularly because the consultant here was like there is nothing really wrong with you".* F2 961,1421

The option of _capitulating_ to a professional was associated with accepting _hopelessness_. The perception of having to capitulate occurs within the context of a _power relationship_ or a relationship in which there is no trust, for instance, perceived _collusion between professionals_, accusations from professionals, _not being listened too_, are all barriers to trust building and _rapport_. _Capitulating_ to a professional means risking judgment in the form of diagnosis and treatment.

5.7.12 Theoretical Code of Consequences

Applying the theoretical code of _consequences_ enabled further integration of the impact of using the _survival strategy_ on pathogenic emotions and pathogenic relationships.

CM-10519-1 Congruence and Main Indicators

What is the relationship between doubt, fear, shame stigma, shriveling identity, isolating and the survival strategy?

Fear is the precursor, the drive, underpins all decisions and behaviours.
Shame is intrinsic and cannot be separated from fear.

Shriveling identity is not the same as a sick identity, but may be develop a shriveling identity to avoid becoming a sick identity.

What is the evidence for it being a survival strategy? What evidence of surviving? It is the path of least resistance. In the absence of growth there is still a desire to exist or survive.

Isolating from people and from toxic environment.

All the above leads to growing incongruence relative to self and others and creates more doubt and more uncertainty.

The more these strategies are used the greater the consequences. They become habitualised and difficult to break out of.

The survival strategy led to reinforcing <u>pathogenic emotions</u>, as there is no outlet for these emotions. Emotion is repressed, denied or overwhelming.

> *'If I dared to realise the depth of the problem with me it would be too overwhelming, too much to cope with'.* E10118-1 F3

Instead there is a focus on:

> *"That was just about …making my little world safe"*. F2 text ref 1903,2322

<u>Pathogenic emotion</u> combined with the experience of <u>pathogenic relationships</u> led to a sense of having to try to make things better by oneself:

> *"And I guess looking back because I can intellectualise things for myself it just fed that and it fed the trying to be my own saviour".* F1 text ref 1726,3051

And can also lead to feelings of <u>hopelessness</u>

> *' 'cos I can't see how I'm going to change and I think I'll always be/feel the way I do'.* NQF442

Summary

The <u>survival strategy</u> is a process of protecting the self from feeling <u>pathogenic emotions</u> exposed by <u>pathogenic relationships</u>. It also protects the self from excessive fear and shame about being sectioned or receiving treatment for mental illness. The consequence of using this strategy is <u>withdrawing from self and others</u> through <u>isolation</u>, <u>losing self</u> and <u>identity crisis,</u> which will be presented in the next section.

5.8 Withdrawing from Self and Others

The sub-core category of <u>withdrawing from self and others</u> emerged as a <u>consequence</u> of using the <u>survival strategy</u>.

<u>Withdrawing from self and others</u> is conceptualised from the data in three ways, <u>losing self</u>, <u>isolation</u> and <u>identity crisis</u>. This section will demonstrate how the <u>survival strategy</u> had a detrimental effect of the self. In chapter one a review of the

literature on self was presented and a definition of self was derived from the literature on how the self develops.

5.8.1 The Process of Losing Self

The process of <u>losing self</u> occurs in five ways: emotionally, cognitively, socially, culturally and spiritually. This is demonstrated through shutting down <u>self-reflection</u> and conscious <u>self-awareness</u>, <u>loss of autonomy</u>, <u>fragmentation</u> and loss of faith. This can be seen through reference to Baumeister's (1999) self as reflexive, agentic and social, and Michael Lewis's (1992) self as consciously self-aware and Gross's (1992) ideal self, self-esteem and self-image.

Fragmentation

The category of <u>losing self</u> emerged from the category of <u>shrivelling identity</u>. The categories <u>shrivelling</u> and <u>fragmenting</u> describe the same thing in a slightly different way.

<u>Losing self</u>,

> *"I will go into a kind of despair because that could have been a moment of hope and I couldn't take it, so now I just start to shrivel".* F1 text ref 4442,4770

Whether losing self through shrivelling, getting smaller and weaker, or through fragmentation, losing touch with parts of self and living in unreality.

Withdrawing or 'shrivelling' is one consequence of damage done by <u>pathogenic relationships</u>, <u>pathogenic emotions</u> and the decision to use the <u>survival strategy</u> that result in <u>hopelessness</u>, <u>loss of self</u>, and <u>isolation</u>. The decision to continue to engage with health services on the basis of dishonesty with self and others leads to further unreality. The use of <u>performance</u> as a way of not looking like a failure may lead to withdrawal away from self and others as a means of protecting the deception from being discovered by others, or 'information control' as Goffman has described (1963: pp.57ff).

> *"I recognise now how fragmented I became over many years starting long, long time ago".* F1 text ref 8192,9038

> **CM-00707-2 Shrivelling and fragmenting**
>
> F1 notes that within the community this is a place where "all the fragments of her are here in one place". She is deciding that what she wants to do is to integrate herself and not use masks any more. F1 has commented more than the others on her having to hide behind social status as a [professional] and the "fragmentation" of this has left her devastated and unable to find herself. Her choice is not to live with 'you don't really know me and I don't really want you to' any more and <u>chooses transparency and openness</u> of the community as a means of pulling all the pieces back together again to form a whole. This description is therefore not just one of <u>shriveling</u> but also of <u>fragmenting</u>. Each descriptor is saying the same thing in a slightly different image, that of <u>losing self</u> whether that is through <u>shriveling</u> i.e. getting smaller and weaker or through <u>fragmentation,</u> losing touch with bits of yourself so that you become less of a person.

<u>Shrivelling identity</u> did not have enough explanatory power to integrate other categories of <u>isolation</u> and the consequence of <u>pathogenic emotion</u> and <u>relationships</u>. Instead using the category of <u>losing self</u> had a wider explanatory power.

Shutting down self-reflection and self-awareness

This aspect of <u>losing self</u> refers to the emotional and social self. Shutting down <u>self-reflection</u> and conscious <u>self-awareness</u> has been demonstrated in sections 5.6.3 and 5.6.4 through the codes <u>difficulties with emotion</u> and <u>fear of emotion</u>. These data demonstrate that the participants were experiencing difficulties in emotional regulation through avoidance, repression or being overwhelmed by emotion. For example, 'filling head with noise' (F5) and not allowing oneself to admit, "how bad bad is" (F3). These emotions became <u>trapped,</u> as they did not have 'a way out' that led to the concept of <u>pathogenic emotions</u>.

If the perception of a unified whole self is formed from both current somatosensory perceptions, memory, emotions, cognitions and social context (LeDoux 1998; Damasio 2000; Gilbert 2010), it follows that if any of these aspects is dominant or absent the self-concept will be affected. The participants all described low self-esteem and self-image with 34 different negative descriptors such as: *'worthless',*

'essentially flawed', 'hopeless', 'making it all up', 'a bother to others', 'rubbish' 'no on will be friends with me', 'everyone hates me'.

Loss of Autonomy

Loss of autonomy reflects the cognitive aspects of self. Loss of autonomy occurs through being denied choice and not having information to make a choice. Feeling powerless especially in unchanging situations and being offered treatments that gave no hope of change contribute to loss of autonomy. One participant described a lifetime of not questioning and not having to take personal responsibility through a process of institutionalisation.

> *" ...you see given my background which was years of boarding school, and the Church of England, that none of these things are going to encourage questioning".* F1 text ref 22466,22650

> *"As a lot of my life has been institutionalised, that's just the way it has been. So working in the church is institutionalised... If the house falls down it's not my problem".* F1 text ref 9748,9945

For another participant it was a history of her parents not giving her information about her medical condition and for three others feelings of not having a choice about treatments for mental illness.

Loss of faith

Loss of faith relates to the cultural and spiritual aspects of self. For two participants loss of self also included a loss of faith and difficulty in their relationships with God. Both described themselves as being non-spiritual.

> *'I used to have a strong Christian faith but have lost much of this'.* NQF239

Summary

The loss of self can be demonstrated in five ways, through difficulties with emotions, separating emotions from cognition, withdrawing from others and loss of faith. All these aspects become disconnected from each other and contribute to a sense of fragmentation or shrivelling.

5.8.2 Isolation

Isolation begins as an emotional separation of self from self and self from others out of fear, which is intensified by the use of the <u>survival strategy</u> to maintain an interpersonal distance between self and others.

Unresolved fear and shame can impact on the ability to socialise, for example, <u>fear of exposure</u>, <u>fear of not being believed</u>, <u>fear of being believed</u>, <u>realising that self-hate and self-judgement are affecting relationships.</u>

> *"Judging, I think I judge myself. So it is hard at the moment through that to see that other people aren't judging me. Because I think everyone hates me that is a difficult question".* F2 text ref 15260,15541

When asked how F4 found settling into the community she replied,

> *"Very hard, very hard. I think because I expected everyone would hate me, that was my beginning position".* F4 text ref 13887,14568

<u>Self-judgment</u> resulted in the expectation for these participants that they would be hated. This <u>self-judgment</u> can be a barrier to being able to make friendships and find support.

Drawing from the quantitative data (see section 5.4.3), the Symptom Checklist-90-R (SCL-90-R), asks how much the respondent has been distressed by feeling lonely. Specific results from this question show no consistent improvement over time for all participants. This suggests that loneliness is different from isolation and more subject to flux and change. This would not be surprising within a community setting that encourages honesty and transparency. It demonstrated that finding relationships in Christ Church is not necessarily the whole solution to feeling lonely.

<u>Isolation</u> occurred through retreating into unreality that effectively begins to cut off relationship with others. <u>Choosing unreality</u> means that the self is not able to be fully present to self or others resulting in <u>Isolating</u> self from self, and self from others.

5.8.3 Identity Crisis

The difficulty with emotions, fear and shame, coupled with <u>isolation</u> leads to distortion of sense of self and personal identity. The list of descriptors below indicates what the participants think and believe about themselves.

> *'A fraud', 'don't know how to change', 'special', 'powerless', 'not going to make it', 'going to die', 'beyond help',' waste of space', 'run out of rope', 'fragmented', 'close to the precipice', 'a burden', 'failure', 'can't do change', 'I am the enemy', 'nervous', 'tongue-tied', 'don't belong', 'never fitted in', 'low self-esteem', 'not honest with myself', 'the problem is me', 'no one must know', 'can't do it anymore', 'trying to be my own saviour', 'failing in the place that is supposed to be for failing people'.*

This long list of descriptions reflects both a sense of self and also identity, which are profoundly negative and conveys hopelessness. For example, 'not being honest with myself' could be a problem within oneself or a general description of somebody who is a liar.

Summary

In this section the sub-core categories of <u>pathogenic emotions</u>, <u>pathogenic relationships</u> and <u>losing self</u> as they emerged in the data have been presented. These categories represent processes that occur whereby the combination of <u>pathogenic relationships</u>, in this context identified as parents, health professionals and church leaders, and pathogenic emotions such as fear and shame become trapped. This is turn results in denying or repressing parts of the self associated with these emotions and withdrawing and isolating from others.

In the next three sections the sub-core categories of salugenic relationships, salugenic emotion and finding more of self are described.

5.9 Introducing Salugenic Emotions

In section 2.4 a definition of emotion is presented focusing on four properties of emotion as valenced, expressed, contagious and connective. <u>Pathogenic emotion</u> is emotion that has become trapped and results in repression or denial of that part of self associated with these emotions and withdrawing and isolating from others.

As a result emotion is experienced as negative. In this section the sub-core category of <u>salugenic emotion</u> is presented. Firstly the definition of salugenic as used in this thesis will be given.

5.10 Defining Salugenic

In looking for a word that conceptualised the type of emotions and relationships emerging in the theory there were none published by Glaser that provided enough explanatory power. In the wider literature the first two words that were found were *salubrious* and *salutary*. Although the etymological meaning of these words was promising, the use of them in everyday speech carries different connotations. *Salubrious* is often associated with luxury or wealth and *salutary* is associated with a lesson learned through difficulty. Another word, from the Latin root *salus,* is salutogenesis refers specifically to Antonovsky's model of health promotion (1996). Antonovsky's 'salutogenesis model' proposes a sense of coherence measured by the Sense of Coherence scale (SOC). Antonovsky defined SOC in his salutogenesis model as a global orientation that expresses the extent to which one has a pervasive, enduring, dynamic feeling of confidence that 1) the stimuli from one's internal and external environments in the course of living are structured, predictable and explicable, 2) the resources are available to one to meet the demands posed by these stimuli, and 3) these demands are challenges, worthy of investment and engagement. SOC has been researched as a predictor of mental health and well-being but not as a definition of mental health (Eriksson & Lindstrom 2006, 2007).

However, salutogenesis is only associated with Antonovsky's model of health promotion and therefore not appropriate to apply as a theoretical code in this theory. As presented in chapter one Peter Holmes and Susan Williams had used salugenic in their research to describe the discipleship journey and the community respectively. However, searching the literature for its previous use led to finding that salugenic had not been attached to any particular model of health or wholeness.

The word salugenic comes from the Latin root *salus* meaning health, welfare, life and the suffix *-gen* meaning producer. There are a number of references to

salugenic sometimes on its own and sometimes used as the opposite to pathogenic.

In section 1 6 the research conducted by Peter Holmes and Susan Williams was introduced. Holmes coined the term 'salugenic discipleship journey' to describe the process of healing occurring in Christ church and Williams the 'salugenic Place' as a theory of the healing and growth enabling social processes in Christ church. The term salugenic religion has been used by Clinebell (1984) as ways to nurture wholeness and healing and Seeber (2001) to describe religion that is health generating. Writing about recovery from addiction to alcohol and drugs White and Scott (2004) propose the community is an aetiological agent that can be pathogenic or salugenic. They define salugenic as healing or wholeness generating. In a paper on medication adherence in Acquired Immune Deficiency Syndrome (AIDS) treatment, Ickovics and Meisler (1997) use the term salugenic to describe potential benefits of protease inhibitors. In an examination of cultural influences on stress and coping Wong, Wong and Scott (2006: p.2) propose healthy cultures to be salugenic. Conducting research on the role of religiosity and political ideology on posttraumatic growth, Laufer, Solomon and Levine (2009) also use the word salugenic as positive growth. In the present theory salugenic is defined as health or wholeness generating/inducing.

The conclusion from this review was that the word salugenic was in use in a number of disciplines none having a prior claim to its definition. It had few if any preconceived associations or connotations in the wider literature. The conclusion was that, despite both Holmes and Williams using it in their disciplines, the use of the term salugenic it the present theory in relation to emotions and relationships was not preconceived. The next section will define how <u>salugenic emotion</u> emerged in the current theory.

5.11 Salugenic Emotion

Drawing on the proposal that emotions have specific properties of valence, connection, expression and contagion, <u>salugenic emotions</u> are emotions that are expressed through <u>self-awareness</u> and <u>self-reflection</u>, and they are able to provide connectivity to the whole self and to others. Salugenic emotion is valenced, but this is viewed as positive in as much as emotion has the ability to communicate

information and evaluation. Using this position <u>salugenic emotion</u> is not the same as positive emotion such as love and happiness (Seligman & Csikszentmihalyi 2000; Fredrickson 2001). Distinguishing between positive and negative emotions in this way can lead to regarding emotions such as anger, hate and fear as harmful. It has been suggested that spirituality equates to positive emotions which are love, joy and peace (Vaillant 2008). However, as Gilbert (2010: p.122) notes people can be frightened of positive emotions such as compassion, affection and kindness. He states that positive emotions are not always positively felt. This theory proposes that all emotion can be viewed as positive and healthy when accompanied by the properties of connectivity, expression, contagion and valence.

A key finding from reviewing the literature on emotion is that emotion is accompanied by cognition and by physiological changes. Therefore, healthy emotion, when combined with cognition, becomes salugenic by helping people to communicate with self and others. The converse of this is that in emotionally repressed states people are severely handicapped by being less able to make rational decisions about themselves and others.

The root of the word emotion is 'movement out' (Damasio 1994: p.139), this indicates that emotions are for communication and to be expressed, they also have neurobiological supremacy over cognition and the body (*ibid* p.160). From various studies of patients with brain injuries it can be concluded that the emotions help us to 'act smart' (Damasio 1994: p.*xvii*). We are not able to make good decisions without our emotions and therefore emotion and reason to go hand in hand.

<u>Salugenic emotion</u> is defined as emotion that is connected, expressed, valenced and contagious. This section presents the findings on how emotion can become salugenic through connecting to cognition so that <u>self-awareness</u> and understanding grows and enables effective functioning. In addition, <u>salugenic emotion</u> generates the capacity to connect with others.

5.11.1 The Emergence of Salugenic Emotions
<u>Salugenic emotions</u> emerged from the categories of <u>self-reflection</u> and <u>self-awareness</u> through the process of emotion and cognition working together

demonstrated by the ability to reflect on both emotion and behaviour and also to recognise its effects on others. This section demonstrates how the sub-core category of salugenic emotion emerged from the data.

Self-reflection and self-awareness

The category of self-awareness has the properties of becoming aware of emotion, becoming aware of 'how bad bad is', and also finding hope. Data demonstrates how the participants are willing to start learning about self through self-awareness. They become aware of how their feelings about themselves affect relationships with others. The admission that self-judgment results in thinking others are judging them causes difficulty in relationships.

Becoming aware of 'how bad bad is'

"So I think being here has helped me to see where the problems are but in seeing where the problems are, it makes things a whole lot worse than when you were going, everything's fine I just want to change these couple of things about myself then my life will be complete". F4 text ref 21195,21468

"But I don't know if I was someone different there than I am here and who I am at work. I don't think, I think maybe I was myself and I didn't recognise myself". F4 text ref 40766,40929

Emotional awareness

"The not feeling judged or where I have felt a bit judged being aware that that person has their own issues and journey. And probably I've got a bit judgmental to someone else at times and that is because of what is happening inside of me, it is not really an accurate assessment of the person just as it isn't of me when it is coming towards me". F1 text ref 1595,18733

Becoming aware of positive change

"there are kind of measures of change. I think because I am coming together more as a person that has changed something". F1 text ref 302,756

Self-reflection

The category of <u>self-reflection</u> has the property of being able to take an objective view of self as 'me'. Self-reflection is difficult when engulfed in shame. These data also demonstrate how the participants begin to reflect on change in their emotions and behaviour. These data do not describe the level of shame and self-criticism that was apparent in the newcomers questionnaire.

> *"And I am in a process of discovering who is [F1] after all these years. Who is she and the number of opportunities to discover what are my sore places".* F1 text ref 18764,19501

> *"Cos I had functioned and I had made everything all right and it's only after a while of being here that you go oh my God, my life is really quite strange".* F4 text ref 18593,18750

As stated above <u>salugenic emotion</u> is not the absence of fear or shame but the recognition that there are emotions driving behaviour. The newcomers joined Christ Church with pre-existing fears about people, authority, being discarded, fearing the consequences of being believed and feeling judged. However, these fears did not become a reality when encountering relationships in Christ Church. The way in which these relationships were different will be discussed in section 5.13 on <u>salugenic relationships</u>.

5.11.2 Expressing Fear

Fear does not disappear but rather new fears emerge such as, the <u>fear of change</u>, <u>fear of change not lasting</u>, <u>fear of connectivity with people</u>, <u>expressing doubt about the community</u>, <u>fear of responsibility</u> and <u>fear of unknown</u>. These fears are different because they pertain to change.

> *"So that is probably where there is a level of denial because I have to some extent I have got used to... But coming out of that won't be trouble free. There will be quite a lot of anxiety attached to that, even if it is done in the smoothest possible way".* F1 text ref 8523,8939

and old fears, such as <u>not being believed</u> and <u>not being helped</u> do not become a reality.

168

> *"Because I had got to the point of thinking I was making it all up and particularly because the consultant here was like there is nothing really wrong with you so, so I don't think it made me feel worse I felt like someone else had recognised that things were difficult".* F2 text ref 961,1421

One participant found she was believed by a mental health professional as well as by Christ Church members.

> *"[The psychologist] understood it all,.. he did have an understanding of like letting out emotion and needing to, I mean he used to be quite in on it when you lot were going on about going shouting somewhere, he would tell me to do the same thing".* F2 text ref 25570,25830

Some fear does not disappear but it is recognised and expressed.

> *"It still worries me cos I know people lose the plot quite quickly don't they?"* F4 text ref 32927,33034

The evidence of <u>self-reflection</u> suggests that shame is not preventing the participants from this process as it would do if they were engulfed by shame. Instead participants are starting to recognise and admit their problems with regard to emotions.

These fears are rational fears, but could prevent progress if not faced and notably these are not fears about church or 'God stuff'. <u>Fear of 'God stuff'</u> was not mentioned again in the data in relation to joining Christ Church. One of the conclusions could be that these fears did not become a reality when joining the community. Alternatively fear of 'God stuff' did not occur in connection with Christ Church because it was no longer a main concern.

The data demonstrate new types of fear emerging, such as fear about the future and anger about mistakes and difficulties in current relationships in the community. The difference appears to be that there was no evidence that these fears became pathogenic during the course of the study. This demonstrates that <u>fear</u> along with <u>self-awareness</u> does not have to become pathogenic. <u>Self-awareness</u> allows the person to evaluate the fear and 'act' beneficially.

5.11.3 Facing up to Fear

In this process either fears did not become a reality or fears were faced up to. The category of <u>Fears not realised</u> or <u>Realised but faced</u> was formed from grouping together <u>feeling believed</u>, <u>felt believed and assured in interview</u>, <u>accepted</u>, <u>risking honesty and being believed</u>.

Other codes of <u>not believing in permanent positive change</u>, <u>ups and downs are hard</u>, <u>making relationships is hard</u> were grouped together under <u>fears realised but faced</u>. These codes demonstrated the ability and capacity to admit to difficulties, problems and fears and not hide from them or deny them.

5.11.4 Confronting Shame

The properties of pathogenic shame are <u>fear of exposure</u>, <u>self-judgement</u>, feelings of <u>worthlessness</u> and <u>hopelessness</u>. These properties contributed to the <u>survival strategy</u> that the participants used to protect themselves. This led to <u>losing self</u> and <u>isolation</u>. The list of descriptors that the participants used in section 5.8.3 demonstrated the beliefs about themselves that were not apparent in data relating to the participants within Christ Church.

Given the participants' previous experience of not being listened to and difficulty with relationships, there might have been to reluctance to join a therapeutic faith community. However, as newcomers they demonstrate the willingness to listen to the stories of others and to risk telling other people about themselves. This reduces pre-existing fears, such as, <u>fear of being judged</u>, <u>fear of being discarded</u>, <u>fear of not being listened to.</u> It also suggests that shame can be overcome and will be discussed further under <u>salugenic relationships</u>.

To be vulnerable to 'external shame', that is shame that is conferred by others through criticism and devaluing, is to be sensitive to the negative thoughts and feelings about the self in the mind of others (Gilbert 2010: p.83). Shame-prone people are prone to feelings of hopelessness (Tangney, Wagner & Gramzow 1992). In the data the participants discuss Christ Church with reference to hope. This could be another indicator that shame is being overcome and which will be discussed this in the next section.

5.12 Finding Hope

<u>Hopelessness</u> was a recurring theme involved in the conceptualisation of <u>pathogenic emotions</u> and <u>pathogenic relationships</u> and is regarded as a key component of shame. There are 35 incidents of <u>hopelessness</u> and 24 incidents of <u>finding hope</u> in the data.

5.12.1 Definition of Hope

Hope is considered to be an emotion as it is felt (Scioli et al. 2011). This is supported by a study that asked subjects to rate similarities and differences between hope, love and anger. The majority of respondents stated that the similarity was that they were all emotions (Averill 1996: p. 26ff). Hope has been defined as an 'intellectual emotion' (Averill 1996) and is also classed as a secondary emotion because it involves cognition. It has also been defined not just as an emotion but also something people 'do' (Weingarten 2000). Defining hope is difficult as it is a complex emotion. For instance, one common definition is that hope is a feeling that what is desired is also possible (Obayuwana & Carter 1982). But another more lengthy definition is that hope refers to an object of desire or want, is connected to personal values and goals, involves the imagination to see the possibility and is also linked to uncertainty in achieving the goal. The hopeful person will act in a manner that supports the hope. (Simpson 2004). Adrienne Martin (2008) writes that hope involves an 'imaginative engagement' such as prayer or 'mental imaging'. The most common psychological definition of hope is Snyder, Michael and Cheavens' hope theory (1991) where hope is defined as the way people think about goals. It is defined as having two pathways. The first is called 'pathways thinking', which is the ability to produce one or more routes to a goal. The second is called 'agency thinking', which is the ability to begin and continue on the selected path to the goal (Snyder, Michael & Cheavens 2000: pp.180-1).

In philosophy Gabriel Marcel (2010) distinguished between 'I hope-that', 'I hope' and 'I hope in thee for us'. 'I hope that' is defined as hope for a particular object or person or event which he proposed was individualistic and contained elements of a wish and a certain belief (*ibid*: p.23). 'I hope' is described contextually as 'I hope for' salvation from difficulty, trial or captivity in other words it is the hope of being delivered from something (*ibid*: p.24-5). Marcel defined authentic hope as 'I hope

in thee for us' which he proposes is the best way to express the verb 'to hope' (*ibid*: p.54). This hope is in 'an active presence in our lives, helping us to keep going in the here and now (Watts Miller 2007).

'Hope as a virtue is an active personal struggle to hold on, against the going-to-pieces of despair' (Watts Miller 2007). Authentic hope is when one holds onto 'broader horizons of hope that are intrinsically tied to what gives one's life ultimate meaning' (Beste 2005). Marcel (2010: p.49) wanted to minimise the role of 'hope-that' out of the idea that it caused a vulnerability to despair by association with desires of material gains. A psychotherapy perspective is provided by Diana Menzies (2001) who suggests that hope is also about meaning and this meaning can be found in 'being known'.

There are suggestions that within the context of healthcare, hope can make a person vulnerable to exploitation and hurt (Simpson 2004; Martin, A. 2008). However, whilst this is a possibility and also feared by Marcel (2010: p.49) as a consequence of 'hope-that' hopes, as Simpson (2004) points out in her definition probability and possibility of the desire occurring are part of hope. In other words plausibility is an intrinsic part of hope along with uncertainty and without adequate attention to plausibility a person has false hope. Hope involves a condition or assumption that one's present life circumstance is unsatisfactory which leads to uncertainty about the future. However, on the subject of false hope Lazarus (1994: p.71) states that all hope is 'false hope' because we cannot know the outcome. If we know the outcome then it is not really hope.

In summary for the participants in this study hope is both 'I hope' and 'I hope-in'. Hope draws on desires that are connected to values and is based on the cultural and relational ethos of Christ Church. Hope is also linked to uncertainty about ones life and about the future. It is hope of personal positive change from their current situation of difficulty is possible and plausible. They also have hope-in or authentic hope as defined by Marcel that puts God and relationships at the centre of hope. The way in which hope is positioned in the present study also draws from goal directed theory of hope. This will be demonstrated in the following section.

5.12.2 Finding Hope

The types of hope emerging in the theory were predominantly 'hope-for' as they reflect relationships that were developing. Hope emerged in this theory as contagious. The codes grouped together to form this category were, <u>believing in the hope that others have</u>, <u>finding hope</u>, <u>positive lifestyle changes</u>, <u>ending of isolation</u>, <u>other people's hope is attractive and infectious</u>, <u>self-confidence growing</u>, <u>experiencing positive change</u>. Hope emerges as a result of <u>positive relationships</u>, <u>being listened to</u> and <u>accepted</u>. It is also a motivator to continue the journey of change despite the new fears that arise. In this way <u>hope</u> begins to foster courage.

"*It is a place of hope, and it's a place of reality*". F1 text ref 9079,10139

This category describes a different process that occurs when pre-existing fears do not become a reality and this results in <u>hope</u> being engendered.

"It felt like here was this interview where I could choose what I was going to say. For the first time I was going to be really honest. I was going to say, and it was like, if I can get it out and can say it and I am still accepted and I am still alive then there really is some hope". F1 text ref 300,1676

'I had run out of options and this promised hope to the hopeless'. NQF133

Participants explain they do not have hope for themselves they value the hope that others have for them.

<u>Believing in the hope others have</u>

"So even sometimes when I struggle with the community I have to remember that it is better than what was happening before…the thing that is helpful is other people having hope for you". F2 text ref 21284,21635

<u>Believing in the hope others have</u>

"…the fact that someone will one comes along and just be there and say I know it is dreadful but we are going to get through this, we are going to make it and people having hope for me, for me when temporarily it is hard to have it". F1 text ref 15945,18733

The data indicate there is a significant shift from hopelessness to finding hope and from isolation to the ending of isolation that occurs from encountering the community. At the start of this process hope is externalised and is conceptualised by the code, believing in the hope others have. This hope combined with ending of isolation is a powerful motivator to take action. As described by Simpson (2004) taking action is part of hope. The theory demonstrates that finding hope and ending of isolation are therefore more powerful than fear, shame, worthlessness and the combined damage of pathogenic relationships and emotions. The joint damage of isolation and loss of self can be changed by hope provided through mutual positive relationships.

Summary
Finding hope can provide a way out of pathogenic shame. The definition of salugenic emotions is not the absence of negative emotion but rather the ability to feel and engage cognitively with all contemporaneous emotion in order to gain knowledge about self and the social environment and interpret that information to make helpful and beneficial decisions. Put another way salugenic emotions teach the self about self and others. This means that salugenic emotion is not an entity solely derived from within the self, but comes from without, from the salugenic relationships.

5.13 The Emergence of Salugenic Relationships

The sub-core category of salugenic relationships emerged from the category of mutual positive relationships.

5.13.1 Mutual Positive Relationships

Mutual positive relationships was formed from the following codes:
Relationship formed through support,

> *"So when I first went she would tell me a lot about things that had changed for her and lots of [my] worries that felt very difficult she kept revisiting and [she said] don't despair, don't think you haven't made progress it is just different facets".* F1 text ref 4501,5421

> *"Having a mentor helps because it's at least one person making you see and they know you".* F5 text ref 13737,14211

"…when he [psychologist] discharged me because he ran out of time he said he believed that I would be okay, which is the only health professional who has ever said that". F2 text ref 25882,26504

"I think for me my GP has been quite key because she has been a consistent reference point from when I first got here. I have always seen the same person and so she has got a kind of measure of objectivity. She is encouraging". F1 text ref 3004,3280

Learning to trust others,

"So it was probably…that I was trusting people more here and, there were a few people in the community who I had more trust relationship with [and] who probably I felt cared or loved me". F2 text ref 3111,3460

"[there are] a range of people who I have got to know and trust and I suppose where there is a degree of reciprocity". F1 text ref 27270,27409

Value of hearing other people's stories,

"When I first started seeing [her] she said, "I tell you what I can do for you. I can give you true, hopeful stories, not kind of clap trap stuff and not my life's perfect now and whatever. But I can authentically say that where something has changed for me that bit has changed. So I can share hope and I can do that with truth"". F1 text ref 4501,5421

Risking honesty and being believed.

"It felt like here was this interview where I could choose what I was going to say. For the first time I was going to be really honest. I was going to say, and it was like, if I can get it out and can say it and I am still accepted and I am still alive then there really is some hope". F1 text ref 300,1676

Believing in the process of personal positive change

"So even sometimes when I struggle with the community I have to remember that it is better than what was happening before…the thing that is helpful is other people having hope for you". F2 text ref 21284,21635

"I have developed a wider range of friendships rather than just ending up getting locked in perhaps with one other person in quite a dysfunctional kind of thing…I suppose that is partly the change that is happening for me and partly a result of things being more stable and secure practically". F1 text ref 24541,26429

Realisation that I am not the only one

"I was like 'Oh my God, everybody else does the same as me." It was really nice, really nice". F4 text ref 9141,9230

"So, it made me think I have got a lot of problems. But I think at the same time it also made me think if there are questions about those problems I can't be the only person who has got those problems". F2 text ref 695,935

Feeling Accepted

"And I guess part of what helps is we know that we are valued, that we are accepted that as we begin to get to know people we start to realise that yea, they do value us". F1 text ref 23151,23320

"I have just seen God at work, I have seen him at work through people, through people's acceptance of me, through people's faithfulness to me". F1 text ref 15945,18733

Mutual interests in relationships

'Like-minded people you can help others and they can help you'. NQF540

'To be with like-minded people in a safe place'. NQF7Q33

'Others like me on the same journey. Others like me want to meet with Christ and have him in charge rather than people. Others [are] damaged and know it-there is an understanding for damaged people'. NQF340

"Because these people are here because they want to be". F2 text ref 12759,12928

Mutual positive relationships have the properties of being narrative, supportive, reciprocal, accepting, faithful, normalising, trustworthy, and generate hope and the possibility of personal change. Mutuality is an antidote to the negative power relationships previously experienced and encourages empowerment of individuals.

> **CM-00625-2 Knowing someone**
>
> Why would anyone want a mutual relationship?
>
> The newcomers have come thinking they are the only ones who are like this. The answers must be found within themselves and in relationship with others who are like them. They have similar stories, similar backgrounds. They find a mutuality that allows them to realise they are 'not the only one'.
>
> Is it possible know all about someone and not hold power over them? Instead by telling a story of how sick we were/are and how we are learning to overcome and find healing. Then we can no longer hold a position of power. Authority that is not grasped, but becomes authority through the authenticity of the journey. Experts by experience.

The category of <u>mutual positive relationships</u> conceptualised dyadic relationships. Further conceptualisation of the theory was carried out through applying the theoretical code of <u>context</u>.

5.13.2 Theoretical Code of Context

The <u>context</u> of <u>mutual positive relationships</u> in these data was found to be in Christ Church and the health services. Within the health services F4 discovered a supportive community specifically in the context of her medical condition. This medical community helped her to find hope that she was not to blame for her condition and that she was 'not the only one'. F1 and F2 formed good relationships within the <u>context</u> of the local health services that added to a feeling of stability.

The application of the theoretical code of <u>context</u> helped the development of relationships from a dyadic model to a contextually situated model within supportive communities. There was not sufficient explanatory detail in the dyadic model and applying another theoretical code of <u>conditions</u> helped to further integrate the theory with other categories.

5.13.3 Theoretical Code of Conditions

Applying the theoretical code of <u>conditions</u> to <u>mutual positive relationships</u> in the <u>context</u> of Christ Church and the health services helped to further integrate the theory. This led to finding five conditions under which mutual positive relationships

operate in these contexts, they are categorised as <u>finding freedom</u>, <u>finding safety</u>, <u>finding hope</u>, <u>finding stability</u> and <u>choosing openness</u>.

<u>Finding freedom</u>

> *"I guess the difference is that if I didn't feel that you, had heard what I had said then I feel I have got the freedom to email and say that isn't what I said".* F2 text ref 15873,16104

> *"I am more aware of when I have got choices and can I see more when I would just be self sabotaging myself… and I think I have seen real things change".* F1 text ref 15642,15855

In discussing her relationship with her mentor:

> *"Cos we've really cracked on with stuff with her and she doesn't pressure me, because she doesn't pressure me I can do it, rather than feeling I have to meet her expectations".* F4 text ref 36185,36532

<u>Finding hope</u>

There were three properties in the category of <u>finding hope</u>, which were finding hope in the place, finding hope in others and finding hope within self.

Finding hope in place

> *'I had run out of options and this place [Christ church] promised hope to the hopeless'.* NQF133

> *"It is a place of hope, and it's a place of reality and it's having hit bottom that gradually the very small steps are none the less hopeful ones because there come be that little bit of being real".* F1 text ref 9079,10139

> *"And the general ethos here is one of hope. Even though I actually don't have any hope at the moment I can see that other people have hope".* F2 text ref 12355,12492

Finding hope within self

"Maybe there is hope. Well, it is just not normal for me. It's really weird. I could be like a normal person". F2 text ref 679,907

'I have hope I can change/grow into wholeness'. NQF240

Finding hope from others

"the fact that someone will one comes along and just be there and say I know it is dreadful but we are going to get through this, we are going to make it and people having hope for me, for me when temporarily it is hard to have it". F1 text ref 15945,18733

The thing that is helpful is other people having hope for you. F2 text ref 21284,21635

In explaining the role of her mentor:

"It has been unbelievable actually when I look back at it. And sometimes when [my mentor] goes right you have done this and you've done this and you have done this and do you remember you thought this, and reminds me. I do remember and she links it all together for me and I go of course, of course". F4 text ref 41069,41548

Finding safety

"Here finally is my safe place and so here challenges me to grow because I try to take too many steps and fall over and that is okay". F1 text ref 18764,19501

"And I think I would say that I have found safety within it, more than that I would say it is a safe place". F1 text ref 34728,35001

Finding stability

"I still swing between extremes and I am sure I'm wouldn't be alone in doing that, but I am probably more able to come back to a more middle ground place. I think for me my GP has been quite key because she has been a consistent reference point". F1 text ref 2536,2956

"I think, things were okay in the house at that time, things were more stable so I could be more". F2 text ref 3111,3460

<u>Choosing openness</u>

"and actually the more information I give G.P. the more she will be able to help, because she can't mind read". F1 text ref 11348,11458

"…and able to share honestly at least to a degree about where I am or how things are". F1 text ref 29061,29349

"So I think for me quite a good bit is there are now several women where I would feel actually there is a level of more real engagement with several people... I would say that I am not thrown by them being honest where they are at and their wobbles". F1 text ref 28904,29059

'There are trust issues because we don't trust that by being what we are, honest about how we are, we will get out of the place we are in… I now have real hope, so it is easier to admit to more because I feel safer'. E 10120-01-F3

Integrating these categories together demonstrates how <u>mutual positive relationships</u> become the basis for <u>salugenic relationships</u>. <u>Salugenic relationships</u> are <u>conditional</u> on safety, hope, freedom, openness and stability. These <u>conditions</u> are found within <u>mutual positive relationships</u> and the culture of Christ Church. That is to say that the 'ethos of hope' is found not only in dyadic relationship but also within the whole church. Therefore the cultural context helps reinforce the relational and the relational reinforces the cultural. The inclusion of health care relationships in these data illustrate how significant these relationships are to the participants and how they contribute to an overall sense of stability. What is not evident from these data were how many of these <u>conditions</u> were also present within the <u>context</u> of the positive health relationships, for example, the relationship with the G.P. The theory does not propose whether <u>salugenic relationships</u> are <u>conditional</u> on safety, freedom, stability, hope and openness all being present at the same time.

5.13.4 Finding Safety

The excerpts from the data above illustrate that <u>finding safety</u> was mostly linked to a 'Place' but as Christ church does not have a physical place it is inferred that the participants were suggesting a 'virtual Place'. Christ Church was considered to be a safe place. For one participant it was the recognition that Christ Church was a place where there was safety in the process of learning to grow. She used the analogy of *"falling over"* as a consequence of taking too many steps too quickly in learning to grow. For another participant safety was linked to relationships, in that she needed to know there would be someone to *"put me back together again after dismantling myself".* From these data <u>finding safety</u> has the properties of having a framework in place that allows a person to take risk and feel supported. This includes the safety to allow emotions to surface without fear of being left without support. <u>Salugenic relationships</u> offer safety to those who are choosing reality, choosing transparency to reconnect their emotion and cognition.

In previous section <u>pathogenic relationships</u> were not characterised by safety, instead there was a risk of <u>being judged</u> and <u>not being helped</u>. Therefore deciding to <u>risk honesty and being believed</u> establishes a sense of safety. In the context of <u>being listened to</u>, <u>risk honesty and being believed</u> results in the realisation that they are <u>not the only one</u>, <u>not judged</u>, and <u>accepted for who they are.</u> As their <u>Fears not realised</u> the person <u>feels listened to</u> and <u>valued</u>, then a <u>salugenic relationship</u> can start to grow*.* Being <u>accepted for who I am</u> is another precursor for feeling safe and the antidote to <u>being judged</u>.

5.13.5 Finding Freedom

From these data <u>finding freedom</u> was characterised as the freedom to agree or disagree, and the freedom to make choices, which related directly to previous experiences of being denied choice within the church and health contexts. <u>Finding freedom</u> in a non-stigmatising environment along with <u>finding safety</u> enables openness and transparency to develop without fear of judgment.

Freedom is linked to safety in that the person needs the freedom from constraints in order to grow and explore but without judgment. This relationship in the data points towards the freedom from judgment as being a condition of <u>finding safety</u> within both dyadic relationships and the church as a whole. The excerpts above

illustrate the freedom from judgment allows the freedom to be able to clarify oneself and to have choices in their own personal journey.

5.13.6 Finding Hope

From the excerpts above the participants express their view that Christ Church is a place of hope. Drawing on Marcel's (2010) concepts of hope this is 'hope of' being able to change. 'I hope in' refers to the data concerning Christ Church ethos of hope. For example:

> 'a therapeutic community where Christ is the focus. A place where people help you sort out your problems and vice versa'. NQF437.

This 'I hope in' may be implicit in the interview data rather than explicit as in the newcomers' questionnaire. The hope that is explicit in the interview data is the hope that others have which is contagious for the participants. This is expressed as vital for when they have no hope for themselves. This hope becomes internalised.

Being believed contributed to generating hope. This indicates the beginning of a supportive relationship as opposed to perceiving judgment that contributed to pathogenic relationships. Being believed were codes associated with positive outcomes such as feeling valued, not judged, learning to trust, accepted for who I am. This is in direct contrast to the perceiving judgment and feels falsely accused that emerged from the pathogenic relationships and reinforced feelings of low self-worth and being the enemy. Being believed can be both cognitive and emotional as it is described as a knowing and a feeling that suggests an emotional connection is formed during the listening process.

5.13.7 Openness

Data showed that newcomers tested new relationships by exploring whether others would listen and by choosing to listen to others, rather than remaining in isolation, shame, lost trust and fear which had been the prior experience. For some participants listening to others gave them courage to talk. For others, talking first reduced their fear and increased courage, after which they demonstrated

listening to others. The key finding is that telling one's story and listening is mutual and reciprocal.

Openness is a two-way reciprocal process. The participants demonstrate listening to others through the codes <u>value of hearing others stories</u>. It is part of the narrative culture in Christ Church.

CM 00628-1 Why do they believe others?

Why believe in those who have a hope for change and hope for the future?

From the data in instances of positive relationship interactions have been those where her participants have realised that they are not the only ones. E.g. F4, F1 If they realise that they are not the only ones then they must have heard stories from these individuals who are saying I was the same or I am the same but this is how I am dealing with it. It is not a case of someone saying I do what I say not what I do. Rather the actions go with the words.

The thrust of the salubrious relationship is the use of experience rather than theoretical knowledge. It is not claiming to have the answer for everyone but simply saying have you tried this it worked for me given within a genuine desire to see change and having experienced genuine change. It is given without judgment. **Experts by experience**.

<u>Openness</u> and <u>transparency</u> emerges as the willingness to relate personal stories as a means of explaining the journey to another but it extends to being willing to speak out inner thoughts and feelings rather than keep them hidden or repressed, which is an antidote to <u>self-deception</u>.

> *"So I think being here has helped me to see where the problems are but in seeing where the problems are, it makes things a whole lot worse than when you were going, everything's fine I just want to change these couple of things about myself then my life will be complete".* F4 text ref 21195,21468

5.13.8 The Theoretical Code of Coupling

Salugenic relationships can be partly described as a basic psychological social psychology process, which does not follow a linear trajectory of cause and effect. Instead a different theoretical code was required.

Being believed and the value of hearing others stories without the need to classify or categorise creates conditions of safety, openness and trust to develop. Coupling is a term used to describe the impact of emotional contagion on neural circuits that form a feedback loop. Each person changes with the other and so on. Coupling is found in systems theory and was also used by Goleman (2006: p.39) to explain the nature of social relationships:

> 'during this linkup brains 'couple', with the output of one becoming input to drive the workings of the other, for the time being forming what amounts to an interbrain circuit. When two entities are connected in a feedback loop, as the first changes, so does the second'.

'Coupling' helped to conceptualise what was happening between the core categories of positive relationships, listening to others, feeling accepted, choosing openness and transparency and hope. It was not possible to see the relationships as either one-way or simple cause and effect, rather 'coupling' helped to explain how acceptance, openness and transparency was enabled between both parties. The greater the sense of 'coupling' the safer the person felt and more trust developed to become more open and feel more accepted. This becomes a potent illustration of 'coupling' where listening embraces acceptance and openness in the context of mutuality and positive power (Goleman 2006: p.40).

The concept of coupling is used as a theoretical code to explain and describe the impact of the salugenic relationship and the impact on emotions. Many of the indicators in the data related not only to emotions but also to emotion, cognition and behaviour.

Summary
Salugenic relationships emerged from the category of mutual positive relationships. These relationships are based on mutual trust and support and include acceptance and honesty. Another property of salugenic relationships is that they are situated in a church community context. The context reinforces the conditions necessary for salugenic relationships such that hope, safety, freedom stability and openness are not only characteristics of the dyadic relationships but also of the culture. Therefore the participants find hope and safety in both the place and the relationships. Salugenic relationships provide the antidote to power

relationships, judging and self-deception that enables the newcomer to find hope of change, acceptance for who they are, and openness in relationships with others.

The next section demonstrates the integration the two sub-core categories of salugenic emotions and relationships to develop another sub-core category of finding more of self.

5.14 Finding More of Self

In chapter one the theories of self were presented and defined through focusing on how the self is constructed emotionally, cognitively, socially, culturally and spiritually. In addition Baumeister's definition of the self as agentic, reflexive and social, supports the theory of finding more of self. In section 5.8.1 the sub-core category of losing self is demonstrated as a consequence of the difficulty with emotions and trapped emotion discussed in pathogenic emotions and pathogenic relationships. These are relationships that do not offer support with trapped emotions and have the properties of unequal power and loss of trust. The combination of unequal power and loss of trust led to the concept of a survival strategy in order to protect the self. However, the survival strategy results in withdrawing from self and others. This isolation results in loss of a unified and whole sense of self. In section 5.11.1 the characteristics and consequences of salugenic emotions were presented. Salugenic emotion is defined as emotion that is connected to cognition and is demonstrated by growing self-awareness.

In section 5.13 the characteristics of salugenic relationships were presented. One such characteristic of these relationships is that they introduce salugenic emotions through contagious hope and allowing expression of emotions through connectivity with others. The relationships are at the core of enabling personal positive change. In the following section the next stage in the process of conceptualising the sub-core category of finding more of self is presented.

5.14.1 Growing Identity

Finding more of self emerged from the category growing identity. This category emerged from the categories of self-reflection and self-awareness that demonstrated a willingness to begin connecting with oneself.

185

One participant describes the feeling of joining Christ Church as a place where "*all the parts of me are in one place*" (F1). This seems to provide hope for future integration of all these parts to form a whole. This is in the context of <u>salugenic relationships</u> that offered <u>safety</u> and <u>acceptance</u> in a culture of <u>hope</u> and <u>freedom</u> through offering choice and personal responsibility. <u>Growing identity</u> is then similar to <u>finding more of self</u>, but the latter encompasses a felt sense of self as a whole person. Therefore <u>finding more of self</u> can be conceptualised as fragmented pieces of self re-connecting.

> *"So however fragmented I still am, the fragments are here, so at least it feels like, I may not be integrated yet, [but] it's not apparently completely different people operating in divorced zones. It is at least bits of one person... So I think the huge thing for me is this is a place of being to come together".* F1 text ref 9078, 10139

<u>Salugenic relationships</u> help to create conditions necessary for the fragmented self to find hope of re-connecting emotion and cognition in <u>self-awareness</u> and <u>self-reflection</u>. They provide non-judgmental, mutual, safe relationships. The self can then re-construct emotionally, socially and culturally. The spiritual dimension to the relationships and culture is implicitly important to these participants as determined by their desire to join a church.

> *'People with the same mind in as much as want to change to move and accept you as you are. And want a loving community'.* NQF333

> *'It's people who believe in God and are interacting with each other in community'.* NQF337

Finding more of self did not simply emerge from dyadic <u>salugenic relationships</u>. The application of the theoretical code of <u>conditions</u> helped to integrate the theory further and identify five <u>conditions</u> necessary in this theory.

5.14.2 Theoretical Code of Conditions

Five <u>conditions</u> were identified that enable the fragmented lost self to begin moving towards change. These are <u>finding hope</u>, the <u>ending of isolation</u>, <u>belonging</u>, <u>participating</u> and <u>autonomy</u>. Finding hope was described in section

4.13.6. In this section the condition of ending of isolation, belonging, participating and autonomy will be presented.

5.14.3 Ending of Isolation

Theoretical sampling was carried out to help fill the gaps in the data concerning motivations for joining the community. Theoretical sampling identified that the main motivation to join the community was to end isolation. This is perhaps a surprising finding given the fear that participants expressed towards people, professionals and the church:

> *'Others like me on the same journey- companionship. Others like me want to meet with Christ and have him in charge rather than people. Others damaged and know it- there is understanding for damaged people'.* NQF340

> *'The feeling that I have come to 'oddballs united' I am not the only freak around'.* NQF140

The participants demonstrate they have a basic need for relationship. Data demonstrates the benefit of these relationships:

> *"And a range of people in different ways can offer bits of help and that ending of isolation is such a huge thing".* F2 text ref 18396,18509

> *"…I just feel more positive and I think meeting other people has made a big difference as well. 'Cos I was very secretive before didn't talk about it and didn't want anyone to know".* F4 text ref 7075,7363

This was a reference to a personal scale indicating how much she wanted to self-harm:

> *"Oh, also I don't really know where I am in the scale, that's why I stopped using it. I didn't actually know where I was on it. And then I just didn't need it, I use different ways now".* F4 text ref 18039,18418

This participant demonstrates that she no longer needs the scale to communicate her feelings and thoughts.

However, theoretical sampling also identified another code of <u>difficulty of making relationships</u> within the community that was a concern for the participants.

> 'The inevitable difficulty of joining a community with a shared history and network and already established relationships'. NQF141

This is a contradiction in these data concerning the desire for relationships and the benefit of relationships and yet difficulty in making relationships in Christ Church. This resulted in returning to these data to identify whether the participants were specific in the types of relationships that had been beneficial to them and discovering that the participants had been referring to mentoring relationships as the beneficial types of relationship.

What emerges is the importance of mutuality in the mentor and proxy mentor relationships. Whilst the newcomer has difficulty forming everyday friendships, the mentors and their proxies become the reference point for the newcomer in terms of learning about relationships in the community, learning how to trust and be open. This type of relationship becomes a 'buffer zone' between the difficulties of the everyday relationships and joining the community.

5.14.4 Belonging

The codes that were grouped into the category belonging were, <u>accepted for who I am</u>, <u>all in one place</u>, <u>become part of the milieu</u>, <u>choosing to be in community</u>, <u>ending of isolation</u>, <u>finding safety</u>, <u>finding stability</u> and <u>realisation that I am not the only one</u>. <u>Belonging</u> is emergent from <u>salugenic relationships</u> found in the context of a community setting.

> *'Like-minded people in a small friendly town. You can help others and they can help you. You can work together with others and get further into your issues a lot faster than you would do solo'.* NQF540

<u>Belonging</u> is conceptualised as including both individual feelings and wider social connections. <u>Belonging</u> therefore addresses the social and cultural aspects of <u>finding self</u>.

"I guess the huge difference here is it is holistic. It is where I live, it is where people are beginning to know me, it is where I go church. It is where I volunteer to do the bits that I can, it is where I have a good relationship with my GP who's for me. It is all the bits are here". F1 text ref 9078,10139

> **CM-10202-1 Therapeutic community as a way of life**
>
> The difference between CCD and other TCs is that it is a way of life. It is not a treatment with a plan and distinct time frame. It is based on a new way of living.

Being in a community of like-minded people journeying together may not be enough to generate belonging, as <u>belonging</u> comes also from <u>participating</u> and from a sense of continuity.

5.14.5 Participating

<u>Participating</u> is conceptualised from the categories of <u>listening to others</u>, <u>risking honesty and being believed</u>, <u>choosing transparency</u>, <u>choosing reality</u>. All of these actions demonstrate the willingness of the person to participate therapeutically with others in the ethos and activity of the community. <u>Participating</u> reinforces active learning and opposes being a passive recipient of treatment. It also reinforces acceptance, belonging and engenders more hope.

> *"I am still able to do things for other people a little, at the moment, not saying lots of stuff but [friend] was having a bad week and I was able help her talk it through so I was not just focused on myself".* F2 text ref 9227, 9889

5.14.6 Autonomy

The term autonomy was used over agency or self-efficacy, as it is the term used in ethics and mental health law as section 3.10.1. Autonomy is an important aspect of the ethical consideration for this study. There was no word or expression that emerged from the data to take precedence.

The category of autonomy was developed from the following codes, <u>exercising choice</u>, <u>experiencing positive change</u>, <u>explaining taking responsibility is</u>

empowering, self-awareness, self-confidence, self-reflection, shocked by reality, using less coping mechanism.

> *"And as I got more of the structure in place it [is] possible to look at the week and.., I've got a gap there so that would be nice to meet up with someone, who shall I meet up with that I don't usually..."* F1 text ref 13959,15107

A reason for joining Christ Church was given as:

> *'Desperate to leave home and I wanted to help myself'.* NQF533

One participant demonstrated her experience of positive change through a change in her coping mechanism of having constant noise to block out thoughts and feelings.

> *"And I don't need to have my DVD playing all the time any more. I broke it so I tried to do with out it and it has actually been all right".* F5 text ref 21085,21898

Being able to make choices and having freedom to disagree is empowering fro individuals. It offers an antidote to passivity that results from shame and from the survival strategy.

5.14.7 The Five Areas of Finding Self
The findings developed in this theory of finding self demonstrate that participants found that through the ending of isolation by connecting with others in community they felt safety and freedom to connect with themselves. Fear of emotion and difficulties with emotions are faced through the support of salugenic relationships. Hope from others is key to this process. This demonstrates reconnecting with their social selves and through self-awareness and self-reflection connecting with self both cognitively and emotionally. This supports Baumeister's (1999: p.2) definition of the self as reflexive, social and agentic. The agentic self is supported by the category of autonomy in which the participants demonstrate having the freedom to makes choices and take responsibility. The spiritual connection is not explicit in the interview data, however, it is an implicit part of the participants' sense of meaning and purpose as identified in data from the newcomers questionnaire.

5.15 A Grounded Theory of Incongruence and Congruence

5.15.1 Introduction

The theories of <u>pathogenic</u> and <u>salugenic relationships</u> have been presented. <u>Pathogenic relationships</u> emerged as relationships characterised by inequality which promoted <u>pathogenic emotions</u>, a trapped state. This led to a <u>loss of self</u> and <u>identity crisis</u>.

In contrast <u>salugenic relationships</u> facilitate <u>salugenic emotion</u>, socialisation, <u>autonomy</u>, and <u>finding more of self</u>. These relationships promote <u>hope</u> and facilitate <u>salugenic emotion</u> by helping link together emotion, cognition and behaviour, as they are 'experts by experience'.

5.15.2 The Need for Further Theorising

As the conceptualisations of <u>pathogenic</u> and <u>salugenic relationships</u> and <u>pathogenic</u> and <u>salugenic emotions</u> were completed, it became clear that it was not sufficient to have conceptualised the processes involved in <u>losing</u> and <u>finding self</u> without being able to relate them to each other. There was a sense of incompleteness at their core.

Despite some participants trusting their health professionals there was something intriguing about the baseline assessments that had not been totally explained by the theory so far. It suggested that something had changed in the researcher's relationship with the participants or the participants' perception of the researcher between the baseline assessments and the first in-depth interview six months later. There was an expressed lack of trust initially that had changed into trust by six months enabling their disclosure of dissembling in the baseline assessments.

In addition there were data from the participants interviews that were not fully accounted for in the theory so far. For example, a tipping point for F4 was being told that she was not to blame for the difficulties with her medical condition, this led to belief and hope that things could change for her. F1 describes the benefit she encountered from a stay at a Christian hospital, the limitation of which was the need to pay and the short-term duration. F2 describes two different perspectives on the mental health services. The first being that mental health services and professionals did not help her and she lost trust and second that she found one professional to trust who helped her. Outside of these data there researcher's

experience is that there are many people who benefit from the health services and from churches.

There was a gap in theory in being able to conceptualise pathogenic and salugenic relationships to account for these data. In the analytic process of grounded theory this entails searching for a theoretical code to apply to the theory so far to achieve further integration. Referring back to the 'conditions' described as necessary for a good therapeutic relationship in chapter one, congruence is one of the five conditions (Rogers 1961: pp.61-3). The next section presents the discussion surrounding the use of the term congruence as a theoretical code.

5.15.3 Theoretical Code of Congruence

Choosing Congruence, Coherence or Interest Convergence

A theoretical code was sought that could describe the overall meaning of the theory that was emerging. In grounded theory these theoretical codes could be neologisms, which are often adverbs to preserve a sense of dynamism. There did not appear to be a published theoretical code that was able to conceptualise the full meaning. Instead of creating a new word a theoretical code can be chosen by expanding on the meaning behind an existing word.

A word that seemed to encapsulate the meaning was congruence. It is found in psychotherapy literature where congruence is a term often found in discussions about the therapeutic relationship (see chapter one). The Oxford English Dictionary defines congruence as agreement or harmony (*Compact Oxford English Dictionary for Students* 2006).

A literature search revealed a theory for congruence of belief (Rokeach 1968), politics (Eckstein 1997), 'religious congruence' (Chaves 2010), the person-environment fit theory (Edwards 1994; Namini et al. 2010) and in organizational psychology concerning 'emotional labor' (Mesmer-Magnus, DeChurch & Wax 2012). Congruence is also used extensively in mathematics and computing with the same meaning, whereas coherence is defined as pertaining to an argument and means logical and consistent. Of particular relevance was the importance of congruence in therapeutic relationships (Rogers 1957; Kolden et al. 2011; Norcross & Wampold 2011a). As introduced in chapter one, in psychotherapy Carl

Rogers (1957) used the term congruence to mean 'integrated in the relationship' and describes the therapist as 'freely and deeply himself', 'a congruent, genuine, integrated person', and the 'therapist communicates his own wholeness and congruence'. This overlaps with the term genuiness which Gelso and Carter (1994) suggest is an important component in the therapeutic relationship and which is also described together with congruence (Kolden et al. 2011). Congruence in psychotherapy, is one of three 'therapist's conditions' the other two are unconditional positive regard and empathy for the client (Rogers 1961: p.61-2). It is interesting that the onus is on the therapist to achieve congruence. Rogers (1957) suggested that being congruent is related to transparency which is the opposite of 'presenting a façade'. Rogers (1961: p.339) also defined congruence as the 'accurate matching of experience, awareness and communication'. Greenberg and Geller (2001: p.148) propose that congruence needs to be seen as a 'facilitative' process that is embedded in the therapist's three conditions. This means that congruence needs to be considered within the framework of beliefs. This framework of beliefs within 'person centered therapy' involves a 'genuine desire not to have power over their clients' (*ibid*: p.149) and responding in non-judgmental way (*ibid*: p.153).

In comparing congruence to coherence a literature search found references to the area of Aaron Antonovsky's (1996) health promotion model of 'salutogenesis'. This concept was introduced in section 5.10. In this model coherence is found in the term sense of coherence.

Coherence is also found in interpersonal neurobiology, specifically derived from a subsection of the Adult Attachment Interview (AAI), where 'sense of coherence' is evaluated from life story narratives. Coherence is the term that Daniel Siegel uses as an acronym to describe the 'coherent flow of human systems' in terms of, connection, openness, harmony, engagement, receptivity, emergence, noesis, compassion and empathy (2012: p.A1-16). In many ways Siegel's definition of coherence fits with emerging aspects of this theory. In another paper coherence and congruence were used to describe two aspects of personality integration where the proposal made was 'integration occurs when the aspects of one's personality both cohere with one another and are congruent with organismic needs' (Sheldon & Kasser 1995). The rest of the article actually seems to use the terms coherent and congruent interchangeably so does not help to clarify usage.

LeDoux (1998: p.33) suggests that the main job of consciousness is 'to keep our life tied together into a coherent story, a self-concept'. Having a self-concept demonstrates the capacity to have a continuous life story that makes sense.

The last area that appeared to support the theory development was found in a paper describing the mental health system (McCubbin & Cohen 1996). The authors describe one problematic area as 'interest convergence', meaning that the current health system did not meet the needs of their clients and in fact the system would impede and resist reform based on client need. This article did not attempt to research the needs of the client only to identity the models currently used in the health service and consider what other models may look like, especially if interest convergence could occur between patient and doctor. 'Interest convergence' is one significant factor in the current study theory; however, it only discusses structure and does not describe the full picture involving emotions, cognitions and relationships.

In a grounded theory study of children's residential homes describes how the concept of congruence emerged early in the theory development. Anglin's (2002) category of congruence emerged from data concerning the 'flow of congruence' from the headmaster down through the hierarchy (*ibid*: p.70). His concept of congruence contains three properties of consistency, reciprocity and coherence (*ibid*: p.100). Consistency refers to the use of procedures, policy over time, reciprocity includes the sense of mutuality in relationships and coherence refers to a unified belief in the single team or cohesiveness. Anglin (*ibid*: p.103) proposed that full congruence is an ideal that is not achieved, therefore degrees of incongruence is a more accurate concept.

The specific ways that coherence and sense of coherence are used, particularly by Antonovsky and Siegel, precluded its use in this theory, as it would not allow for the full emergence of the theory from this data. Although congruence is a recognised term in person-centered therapy it is not claimed by psychotherapy as a unique term.

Summary
Because the theory that emerged is centered on relationships, the term coherence and interest convergence were not used. Congruence was chosen despite its

familiarity in psychotherapy as it is broader in meaning than coherence. It is a term that is not defined by one discipline and therefore can accommodate its full etymological meaning without preconception and would be appropriate to use as a theoretical code. In the present study the theoretical code of <u>congruence</u> means an agreement with or harmony with oneself, others, cultural and spiritual. Being in agreement with oneself is not to be conflated with being 'happy', rather it implies a dynamic process of moving towards a unified sense of self that includes a sense of coherence. This is accomplished through being connected to emotions, cognitions and facilitated by other people.

The rest of the chapter presents how the theory developed through identifying <u>incongruence</u> as it emerged from the theories of the pathogenic and salugenic relationships.

5.15.4 Theoretical Code of Incongruence

Defining incongruity

Where congruence in psychotherapy is being wholly oneself and wholly within the relationship, Rogers (1957) definition of incongruence is a discrepancy between the actual experience and the self-perception or self-concept. This is proposed as an important condition in the client's state at presentation that enables change. When applied to the findings of <u>pathogenic</u> and <u>salugenic</u> <u>emotions</u>, Rogers proposal can be interpreted as meaning that the client/person recognises there is a fragmentation or disconnect within themselves, particularly with emotion and cognition, and between themselves and other people. This then is how the theoretical code of <u>incongruence</u> is applied in the resent study, a dynamic process of fragmentation or disconnection of the self from emotions, cognitions, other people and the wider environment.

Applying the theoretical code of <u>incongruence</u> to the theory allowed the importance of beliefs to emerge from the data. The theory had already conceptualised how <u>pathogenic relationships</u> result in <u>lack of trust</u>, <u>feeling judged</u> and lead to <u>withdrawal from self and others</u>. These relationships can be conceptualised as incongruent. There is disharmony or disagreement between the two parties.

"… what I felt able to disclose, so I think the help that they could give me was limited to what I felt able to say and by their perceptions [of her professional status]". F1 text ref 6341,6487

CM-10119-3 Incongruity in Healing relationships

Incongruity results from excessive fear from patient, expectations from both sides, presumptions and labeling, assumptions, asymmetry in relationship power, use of defence mechanisms such as control and manipulation.

Incongruity results in lack of trust, ambivalence, lack of rapport, lack of empathy, increase in stress levels.

Withdrawal from self was identified in the data as fragmentation or <u>choosing unreality</u> and can be seen as incongruence as disharmony within self.

> *'For a start I couldn't actually finally present the whole of me, nothing to hide, because of all the fragmentation….it wasn't the whole of me anyway. In some ways it was a "look at me-see why I failed, why it's all over" '.* E10119-01-F1

CM-10119-5 Incongruity within oneself
Participants main concern, I want to be 'known'
How can a person be known if they don't know themselves. This is incongruity at the outset.

<u>Pathogenic emotion</u> is conceptualised as emotion that is trapped or overwhelming. In both instances coping mechanisms are employed to separate self from them in order to avoid the pain, out of fear of falling apart to not feel. In this way <u>pathogenic emotion</u> can be seen as incongruent with self through causing disharmony. In particular, <u>feeling shame</u> causes <u>incongruence</u> between self and self and self and others by promoting withdrawal behaviour seen in the survival strategy in section 5.7.6.

The data demonstrates <u>incongruence</u> that developed between participants and church and faith. Christian organisations became incongruent with their mental

and emotional needs and resulted in crisis. Speaking of her experience in the church:

> *"You see part of my undoing was that I would go to extremes because I am much too open, because they would be like, she is a liability and we need to protect our reputation".* F1 text ref 302,756

Another aspect of faith and spirituality that demonstrates <u>incongruence</u> is that the definition participants gave of a therapeutic faith community was inclusive of God or Christ at its centre. This was an important aspect to Christ Church that was also apparent for one participant who had spent time in a Christian hospital with a mental and emotional illness, whereas the Christian faith is not apparent in the health services.

> *"…for me the crunch of [the Christian hospital], it is this desperate and there was a real level I suppose there of acceptance and gentleness, so I feel very grateful to them".* F1 text ref 8195,8787

Data demonstrated <u>incongruence</u> between participants and the health service by offering treatments that the participants felt had no benefit and no hope.

> *"Well, decent medication and a good psychologist still isn't enough to make me, help me get better".* F2 text ref 11892,11991

This allows the integration of the importance of beliefs into the theoretical framework. The participants demonstrate that they do not believe in the long-term ability of medication, Cognitive Behavioural Therapy (CBT) or psychologists to bring wholeness and healing.

> *"I did feel that a lot…was about learning to manage your condition and learning to accept that this is how you are. And for me learning to accept how I was would have been quite hopeless".* F1 text ref 3153,4284

The causative nature of the beliefs is not explicit from these data, therefore it is not possible to conclude whether these beliefs were held prior to treatment or as a result of treatment failures. However, what is clear is that for two of the participants supportive health professionals added to their <u>finding stability</u> in Christ Church

Summary

Applying the theoretical code of <u>incongruence</u> led to the emergence of incongruent beliefs that were an important determining factor in treatment outcome. Additionally <u>incongruence</u> can be used to conceptualise fragmentation of the self and withdrawal from others as incongruent or disharmony.

5.16 Theoretical Code of Congruence

Introduction

Just as incongruence could be found in many areas that resulted in harmful effects on the self and identity so <u>congruence</u> emerges in many ways in the theory with many beneficial effects. <u>Congruence</u> with others was the first area to emerge in the theory. The theoretical code of <u>congruence</u> is defined as the process of moving towards a unified sense of self, connected with emotion, cognition, other people, and the wider environment.

5.16.1 Areas of Congruence

Applying the theoretical code of <u>congruence</u> to the theory demonstrated the need for <u>congruence</u> to develop not only in the dyadic relationships as Rogers (1961: p.61) proposes but also other aspects of <u>congruence</u>. In the same way that the importance of beliefs emerged through <u>incongruence</u>, beliefs also emerged as important to developing <u>congruence</u>. Therefore the theory of <u>congruence</u> needs to be extended to include wider aspects.

Congruence was found in the relationships that were mutual and open. These relationships, particularly mentoring relationships, described instances of sharing personal stories of change. However, the application of the theoretical code of <u>congruence</u> encompasses many aspects of the participants' experiences and concerns a general definition of the word congruence to describe harmony and agreement. It therefore takes Rogers definition and widens it to incorporate all areas of living.

The <u>congruence</u> found in <u>salugenic relationships</u> is contextualised under Christ Church as a therapeutic faith community and therefore there are wider cultural aspects that the participants demonstrate congruence with. Applying the theoretical code of <u>congruence</u> to <u>finding more of self</u> gave an explanation of the

development of harmony and agreement emotionally, socially, culturally and spiritually. Emotionally through <u>self-reflection</u> and <u>self-awareness</u> of emotions and socially through <u>acceptance</u> and<u> trust</u> on others <u>finding hope</u>. Culturally through the safety, freedom and hope that are inherent properties in the church community and spiritually through acceptance of difficulties with God and faith. Also within a faith community that recognises the potential for healing and wholeness.

The participants are able to describe the benefits of <u>salugenic relationships</u> and freedom to describe doubts and fears. They have seen <u>personal positive</u> <u>change</u> that fuels hope, but also increases belief in the 'journey' and leads to greater <u>congruence</u> with self and others.

> *"For instance, the going to London and realising actually there was a lot of things I could enjoy again or that I didn't need to panic. So although I wouldn't have wanted to use the bus and the underground on my own, with an A-Z I kind of knew actually even if I got completely lost what is the worse thing that can happen? I could walk into a police station, do you know, if I do get lost I am not going to die".* F1 text ref 758,1171

> *"So yes, there are kind of measures of change. I think because I am coming together more as a person that has changed something".* F1 text ref 6107,6572

A key finding is that <u>congruence</u> developed externally first, by which it is meant that being in a congruent environment (culturally and spiritually) and with congruent relationships (social) enabled <u>congruence</u> with self.

As Rogers (1961: p.282) suggested a key to successful therapy was for the client to recognise that they had serious and meaningful problems. This was evident for all participants in the present study. However, the participants had not allowed themselves to engage with the depth and degree of their problems out of 'fear of losing the plot' and fear of not 'having anyone to put them back together again'. There was therefore a degree of <u>incongruence</u>.

Congruence with cultural and spiritual environment

Applying the theoretical code of <u>congruence</u> to <u>finding more of self</u> revealed the importance of belief that had not emerged previously in the theory. Another way of

describing this is in terms of 'environment-fit'. This can be demonstrated in these data from recognising the lack of fit between the participants and their previous environments. In Christ Church these participants had found 'fit' through expressing a sense of <u>belonging</u> and <u>safety</u> that was previously missing. A conclusion that can be drawn is that <u>belonging</u> and <u>finding safety</u> 'fits' with their belief in God as stated in the newcomer questionnaire. The definitions of spirituality given included themes around 'meaning' and purpose. Illustrated by

> '*the core/heart of things and of us as human beings*' NQF138.

For the participants spirituality as faith in God is expressly linked with being human whereas some of their experiences with the health services had resulted in feeling less than human.

One example of a participant's awareness of previous incongruence with God that had begun to change;

> '*Perversely parts of me were working against the possibility of healing, wholeness and integration...almost defying God to at last step in and do something...*' E10119-01-F1

This example demonstrated how <u>finding safety</u> and <u>freedom</u> described in sections 5.13.4 and 5.13.5 allows honesty and self-reflection to explore thoughts and feelings previously unrecognised.

Congruence with others

The theory of <u>finding self</u> demonstrates that <u>salugenic relationships</u> were contextualised within the cultural and spiritual environment. These relationships embody the cultural, spiritual beliefs and ethos, and in turn culture and ethos is perpetuated by the relationships. This demonstrates <u>congruence</u> between the dyadic relationships and culture and faith of Christ Church. For the newcomers <u>salugenic relationships</u> are a 'bridge' into learning and experiencing about the community and its beliefs and practices.

> "*And the general ethos here is one of hope. Even though I actually don't have any hope at the moment I can see that other people have hope and because if I like it*

or not, I have got relationship with people here, I find it easier to not act on my self harming and suicidal thoughts because out of relationship to them I don't want to hurt them". F1 text ref 12355,12492

CM-10519-1 Congruence and Main Indicators

What is the evidence for growing? It is becoming more congruent with self and others so that able to recognise feelings and drives and be able to demonstrate self-reflexive behaviour. It all results in growing congruence to self others and beliefs (less doubt). Growing emotional and social intelligence.

The more these strategies are used the more benefit is derived and the more it becomes habitualised.

For example, through believing in the hope that others have for them. Congruence develops in the dyadic relationship through the willingness to be open and transparent and the sharing of stories of personal positive change. Typically mentors are chosen based on 'fit' by which it is meant the similarity of experiences that results in the newcomer 'feeling that I am not the only one'. In social psychology the belief that one's feelings are different to everyone else's whilst conforming to the group is 'pluralistic ignorance' (Prentice 2006: p.48). Pluralistic ignorance can result in feeling less socially connected. The sharing of personal stories in the narrative culture of Christ Church is the ending to pluralistic ignorance and allows feelings of congruence to develop.

Learning to trust one or two people leads onto learning how to be in relationship with others. For example, mentors are able to teach by example in a mutual and equal relationship where the mentor cannot claim to be 'The Expert' as they are still journeying themselves. They can only claim to be 'an expert in their journey so far', which removes elitism. The absence of hierarchy and unhelpful power enables trust to develop and this trust generates a willingness to become more open and transparent.

> "*I think my comparative confidence in who I am means that I have developed a wider range of friendships rather than just ending up getting locked in perhaps with one other person in quite a dysfunctional or feeding need, kind of thing*". F1 text ref 24541,26429

This support network is not hierarchical, although there are some very experienced members and some that have leadership roles, the main tenet of Christ Church is that 'we are all journeying together' which works to militate against elitism. In the theory the structure of Christ Church is congruent because it allows safety, belonging and trust to flourish quickly, even for individuals who have severe impairment in social relationships. Christ Church also provides back-up relationships and wider networks of relationships to support both mentor and mentee.

Congruence with self

Congruence with self can be defined as internal congruence that develops as a result of experiencing congruence within Christ Church and within relationships that provide a 'bridge' into the culture and spirituality of Christ Church. Congruence with self develops as belief and trust in their hope of change as expressed by others becomes internalised. This is found through the participants' expression of their own experience of personal positive change.

> *"I think one is the coming back of [me] because something has started to change and yes, a friend said to me yesterday she said there is something different, the way you are talking and you are looking".* F1 text ref 20178,20398

Congruence is also expressed as 'being real with myself' and 'finding more fragments of self' coming together:

> *"So it is only when you are able to see and admit what is really wrong that you can start getting any better. Otherwise you are dealing with non real things which change but then you don't feel the change, and that is probably looking at coping mechanisms, but they don't work. I never wanted to cope with how I was feeling in order to change so I think probably the only way you can change is if you have reality. I must have started being real with myself because I realised that by not being real I was getting worse".* F2 text ref 2414,2986

Congruence within self occurs emotionally and cognitively. Emotionally the participants demonstrate self-reflection and self-awareness about their emotional difficulties as expressed in section 5.11.1. Reconnecting their emotions with cognition enables harmony to begin to develop as opposed to the 'psychological tension' of living in the survival strategy of denied or repressed emotions. The next

202

example is an illustration of the oxymoron of finding hope before realising that she did not have any hope:

> *'I thought I had hope at the beginning of this journey but it wasn't until I could see real hope… could I see that I had none… to do that sooner would have led to despair'.* E10120-01-F3

This demonstrates a degree of <u>congruence</u> within herself through being able to look at her true feelings and thoughts.

Cognitively learning from others' stories about how they were able to look at and begin dealing with issues provides the 'way out' that the participants had been looking for. The development of self-congruence is demonstrated by:

> *'The key real, significant changes have been when I have had a breakthrough because it has bought about a greater measure of freedom, choice and change'.* E10129-01-F1

<u>Congruence</u> is also expressed through the freedom to express doubts about the community and the difficulty of making new friendships. This demonstrates that the process of joining Christ Church and adjusting expectations of what Christ Church and offer is not an easy one.

> *'Workshops/books/initial meetings gave impression that CCD [Christ Church] was more supportive/organised/structured than in reality. Therefore original expectations not met leading to some disappointment…but I have started to adjust to different expectations'.* NQF241

One consequence of <u>pathogenic relationship</u> was powerlessness that intensified feelings of hopelessness and despair. The antidote to this was to be offered the choice to take personal responsibility to change. This provoked new fears, especially the fear of change itself, but being offered choices also offered hope. This hope is based on the hope that others have and hope of change (see section 5.12.2).

Autonomy is a result of <u>congruence</u> between emotion, feelings, thoughts and behaviour.

203

"So yea, am I more aware of when I have got choices and can I see more when I would just be self sabotaging myself, yea, more of the time, not all of the time. Yea, and I think I have seen real things change". F1 text ref 1562,15855

These components become synchronised and provide knowledge about the self and the reactions to the world around. In <u>being offered choice</u> and <u>autonomy</u> to find their own answers and make their own choices about their healing, Christ Church can be said to conform to many of the ethical standards required of other healthcare institutions.

"If you are taking responsibility for yourself then you are not powerless I guess". F2 text ref 14726,15232

Although accepting personal choice is sometimes a very hard transition to make for newcomers who may have become used to passivity and dependency, the data demonstrates that freedom and choice are highly valued in the community and seen as empowering.

5.16.2 Summary of Qualitative Results

In summarising the grounded theory of congruence and incongruence both are externalised before they become internalised. Pathogenic emotion is conceptualised as emotion that is incongruent, that is to say, it is not connected to cognition, not expressed and can be felt to be negative. It results in barriers with others. Pathogenic relationships have properties of unequal power and loss of trust. They are therefore incongruent by reinforcing pathogenic emotion that can lead to the use of a survival strategy. In combination this process can result in loss of self. Incongruence with belief in the 'medical model' and doubts about the church and God contributes to the process of losing self.

Salugenic relationships develop congruence through mutuality and trust that facilitate salugenic emotion. Salugenic emotion is emotion that is congruent with self through being connected to cognition, expressed, valenced and contagious such as hope. Finding self is conceptualised through a process of integrating emotion and cognition in conditions of safety, hope, freedom and belonging. A congruent self was the essence of being human and being treated as a human

being. This process involved congruent belief that was demonstrated in Christian faith, therapeutic community and the *Rapha* discipleship model of wholeness.

In the next section the application of incongruence and congruence theory to the quantitative results is presented.

5.16.3 Applying Incongruence and Congruence Theory to the Quantitative Results

The decision to use a mixed methods study has resulted in several findings many of which were not anticipated at the start of the study. Applying congruence theory to the quantitative results demonstrates that measuring improvement is a complex concept. There are many confounding factors involved in the interaction between the researcher and the participant. These have been conceptually developed in the grounded theory are proposed and listed below:

- The participants developing greater self-awareness and self-reflection such that the self-report measures become more challenging
- Increasing trust between researcher and participant
- Participants decrease in fear through factors such as trust, belonging, safety and freedom
- Participants decrease in shame as result of being accepted and reduction in pluralistic ignorance
- Participants desire to demonstrate change to self and researcher

The contextual dissemblance demonstrated at the baseline assessments led to reconsidering the analytic framework. However, the theory of pathogenic relationships and incongruence is relevant and proposes that at the baseline assessments the researcher was the focus of a pathogenic relationship through suggesting a mental health context. This was incongruent to the participants through a reminder of past negative experiences provoking an emotional reaction of fear and shame that drives dissemblance.

The decision to use grounded theory method has done justice to the main concerns of the participants. Combining grounded theory data with the quantitative data has provided a richer theory to emerge than if this data was not collected.

5.17 Summary

This mixed methods study of Christ Church a therapeutic faith community has resulted in two distinct findings from the baseline assessments. Firstly, contextual dissemblance demonstrated by the same person representing different contexts for the participants. Contextual dissemblance was due to participants reacting with fear and shame. Secondly, the growing self-reflection and self-awareness of the participants over six-months led to them concluding that they had not been capable of answering the outcome measures accurately because of self-deception.

The grounded theory of incongruence developed from qualitative data provides a theory of pathogenic emotion and pathogenic relationship to explain the process of contextual dissemblance. The theory of congruence provides a conceptual framework for finding self through salugenic emotion and relationship in a context of congruent belief. In the current study the participants are congruent with the belief in a Christian faith, in the therapeutic community and *Rapha* discipleship models.

The overall results from the outcome measures were inconclusive. However, the strength of the study is having been able to integrate the findings from both the quantitative and qualitative arms resulting in a theoretical explanatory framework that contributes to the understanding of research processes and to social psychological processes.

6 Discussion

Introduction

This concurrent mixed method study was conducted over a two-year period in an open therapeutic faith community called Christ Church. The primary aim of the study was to establish if there were any health benefits in belonging to Christ Church. The participants in the study were all newcomers to the community. The quantitative arm of the study was designed around outcome measures, Clinical Global Impressions Scale (CGI), Symptom Checklist 90 items-revised (SCL-90-R) and the World Health Organization Disability Assessment Scale (WHODAS-II). The qualitative arm of the study collected data from newcomers questionnaires and in-depth interviewing analysed by grounded theory method. All participants, except one, had been previously diagnosed with a mental health disorder and treated by primary or secondary health services.

A core finding from this study concerned dissembling used by the participants at the baseline assessment. The baseline assessments involved the use of the M.I.N.I. diagnostic interview followed by the outcome measures. At the six-month assessment the participants disclosed that they had concealed their real feelings and thoughts and one participant claimed she lied because she was self-deceived. The declared reasons for dissembling information was the fear of being judged mentally ill such that the mental health services would need to be involved and might lead to sectioning. Three participants mistakenly thought that the researcher was able to legally section a person under the Mental Health Act.

Five of the participants had previous experiences of being admitted to a mental hospital or an outpatient facility. Another participant worked indirectly in the sectioning process for others. They described these experiences in negative terms and therefore one can infer that previous experience contributed to holding these fears and that the participants brought their fears of the mental health services to the baseline assessments.

The in-depth interviews were carried out after the six-month assessments. Two questions were used to initiate conversation. These were, 'How did the participant find the first six months in Christ Church?' and 'How did they find completing the

baseline assessments?' The interviews produced data relating to their previous experiences in hospital and mental health services as well as data concerning Christ Church. The participants were open about their reactions to the baseline assessments.

This chapter will begin with discussing the dissembling at the baseline assessments and the impact of this on the data. This will be followed by a discussion on the study design and on the choice of an outcome study for the context of Christ Church. Finally, a discussion on the grounded theory of incongruence and congruence will be presented. This includes where the theory is situated in the wider literature, the implications of this theory for the mental health services, therapeutic communities, and Christ Church and the validity of the grounded theory.

6.1   Contextual Dissemblance

For participants in the present study the researcher's occupation as a mental health professional outside of Christ Church, took precedence over the insider status as a member of the community. This resulted in what the researcher termed 'contextual dissemblance', meaning that the context contributed to the action of dissembling. The findings suggest five possible ways in which context contributed to the fear of mental health services and to dissembling:

- The participants attributed a mental health professional status to the researcher in the baseline assessments that changed the context of the interview.
- The use of the diagnostic interview and outcome measures changed the context.
- The completion of the outcome measures at that time was influenced by fear and shame associated with the medical context and led to dissemblance.
- The participants' perception of the researcher's role on the Christ Church Risk Management team was similar to attributing a mental health professional status.
- A combination of these factors increased the 'medical contextualisation' resulting in dissembling.

6.1.1 Context

The significance of context can be discussed from deciding whether to adopt the view of Christ Church as a church or as a therapeutic community. It is clear that members of Christ Church consider it to be both and for the purposes of this study no conscious distinction was made. However, the design of the study focused on a therapeutic community approach with respect to reviewing literature on therapeutic communities and not on churches. This complex cultural identity means that the use of outcome measures is challenging. This is discussed further in Section 6.4.1.

The other aspect of context is that Christ Church is a non-medical environment, in as much as, medical terminology is not used and there are no paid staff therefore professionals are not used within the community. Instead Christ Church works with outside agencies when needed. The newcomers viewed Christ Church as a church as well as a therapeutic community. Therefore, using medical terminology introduced a language and culture not previously found in the community that provided an element of incongruence into the context.

Contextual dissemblance is supported by findings on dissembling in completion of outcome measures documented by Kaiser and Priebe (1999) who noted different scores depending on the whether the interviewer was the case manager or an independent researcher. Various motivations were proposed including the need to please the case manager in a residential care setting. However, the present study findings go further through demonstrating that the same researcher can represent a different context.

6.1.2 Emotionally Triggered Dissemblance

Contextual dissemblance demonstrated an emotional reaction of fear and shame. Oatley (2001: p.xviii) states that 'emotions are central to mental and social life because they are fundamental mediators between inner and outer worlds'. Fear of the researcher is supported by literature on the relationship between context and emotional memory recall. For instance, in posttraumatic stress disorder (PTSD) sounds and smells can trigger a traumatic response through the re-contextualisation of everyday life (van der Kolk 1994). This has led to the development of virtual reality therapy to aid re-engagement with emotional

memory enabling catharsis in the treatment of PTSD (Rothbaum et al. 1999; Difede et al. 2007). The association between memory recall and context has been documented by Fisher and Geiselman (2010) and developed into the cognitive interview (CI). The cognitive interview is a tool for police officers interviewing victims and witnesses of crime to aid memory recall through allowing the interviewee to recreate the context of the crime. The present study demonstrates the relationship between context and shame in the baseline assessment. Social psychology research has demonstrated that subjects were unaware that context had influenced their evaluation (Nisbett & DeCamp Wilson 1977). Psychotherapy research has demonstrated that subjects affect is triggered outside of their conscious awareness and that this can happen through 'implicit associative memory' (Westen 1999). In addition, subjects can actively defend against the awareness. This underpins the mechanism in PTSD and emotional memory recall.

The shame reaction can be discussed in relation to self-conscious emotions, which are dependent on the capacity of a person to self-reflect on perceptions and draw inferences from others as a comparison and potential judgement of self's shortcomings. These emotions can be elicited either in real or imagined social situations and involve the ability to self-reflect which has been defined as a unique aspect (Leary 2004). However, Beer and Keltner (2004) propose that self-focused attention (self-awareness) always heightens other emotions and suggest it is not a unique feature of self-conscious emotions.

The language used in the SCL-90-R and the WHODAS-II is 'plain English' and not medical terminology. This leads to the conclusion that the diagnostic interview introduced the medical context, specifically psychiatric, into the situation that contextualised the outcome measures as psychiatric. This provoked an emotional reaction linked to previous experiences and hidden fears about the mental health services that affected behaviour.

Lazarus and Lazarus' (1994: p.5) cognitive-motivational-relational theory states that emotions are the products of personal meaning, it allows for emotions to be highly individualised as every person has a unique and different way of reacting to contexts and events (Pattison 2000: p.29). But it also allows for generalised patterns and broad labels to be assigned to emotions.

6.1.3 The Place of Trust

Contextual dissemblance was demonstrated through lack of trust in the researcher at the baseline assessments. Lack of trust was firmly related to the fear of mental health services and fear of being sectioned. The participants' previous experience of dissembling with health care professionals was described during the in-depth interviews which adds weight to the conclusion that some trust had begun to be developed between the researcher and the participants.

Establishing trust is a key component in human research whether as an insider or outsider researcher. Identifying areas where there is lack of trust between the researcher and the participant is an essential part of the research process. Glaser (1967: p.226), Freilich (1970b: p.2), Charmaz (2006: p.15), Atkinson and Hammersley (1998: p.65) to name some, all emphasise the need to develop trust with the participants or those who are being observed.

6.1.4 Unequal Power

It had been falsely assumed by some participants that the researcher had the legal authority to section a person. This misunderstanding contributed to the fear and lack of trust at the baseline assessment. Doctors and Approved Mental Health Practitioners (AMPs) have the legal authority to section persons under the Mental Health Act in the United Kingdom. These professionals therefore embody the authority that is inherent in medical and other health care professions as well as the Law. Coercion has long lasting damaging effects on trust in mental health (Laugharne, R. et al. 2011). It has been proposed that as long as the legal right to detain mentally ill patients remains there can be no real trust (Colombo et al. 2003).

It is not possible to say how much the researcher's professional occupation continued to influence the data. But according to Atkinson and Hammersely (2007: p.78) and Denscombe (2010: pp.178-9) for example, there are many characteristics of the researcher that can influence the data including gender, ethnicity and occupation. The content of the interview data leads to the conclusion that the researcher's occupation acted as a 'lightning rod' or 'sensitiser' to the conversation. This is not the same as inferring that the interview data was the result of dissembling.

6.1.5 Self-deception

The other motivation cited for dissembling was lying which one participant defined as self-deception. Self-deception is described in the current study as repressed or denied emotion and living in unreality such that there was a profound inability to answer the questions accurately. The admission of self-deception was made at the six-month assessment from which it can be deduced that the participants were able to reflect and become aware of their own difficulties with emotion and with their self-concept.

The admission of lying because of self-deception indicated that there was no deliberate intent to deceive another person. The issue is how and when a person becomes aware of their own dissemblance and how they communicate this to others. Until that point is reached the responses given on outcome measures may be as accurate as a person is capable of determining, but may not reflect the reality of feelings and experiences. This is further discussed through the wider literature in the next section.

6.2   Dissembling, Lying and Self-deception

There is an extensive literature concerning dissembling with regard to assessments. Studies on 'response styles' to assessments have generated evidence on seven different types of responses (Rogers, R. & Bender 2003: pp.109-10). These responses are:

- Malingering - deliberate lying or exaggeration of symptoms for an external goal
- Defensiveness - polar opposite of malingering, gross minimisation of symptoms for an external goal
- Irrelevant responding - disengaging with the process
- Feigning - deliberate lying or exaggeration without assumption about its goals
- Secondary gain - perpetuation or augmentation of symptoms for unintentional internal or external reasons
- Suboptimal effort - maximum performance not achieved because of tiredness or illness
- Dissimulation- inaccurate portrayal of symptoms.

Dissembling in the present study is supported by the dissimulation found in the study above. There was no evidence from the present study to support any other response styles presented in section 5.4.1.

6.2.1 Dissembling and Power Imbalance

One study identified patients lying to their doctors with respect to medication adherence and concluded that dissimulation was related to power in the relationships (Fainzang 2002). The patient resists the power of the doctor and also exerts power by lying about their non-adherence with medicine. But this resistance is hidden and it is a refusal of 'open opposition' (Fainzang 2002). Fainzang goes on to propose that lying is induced by the power relationship specifically by authority. However, it is in fact paradoxical because lying also reinforces the power in the relationship.

> 'We therefore find ourselves facing two situations where the subject is put into a position of lying, in the first instance because he has power, and in the second because he hasn't' (*ibid*: p.8).

Dissembling in the present study was consistent with the results from another study researching the issue of trust between patients with serious illnesses and their doctors. The study found that the group of patients with mental illness were more likely to withhold and conceal information from doctors than patients with breast cancer and Lyme disease (Mechanic & Meyer 2000). The stated reasons given by the patients were due to fear of the doctor's reaction and fear of punishment by having a desired treatment withheld or denied. These studies support the process of dissembling in the present study where dissembling is the attempt to retain personal power against the power of the medical and legal system in which they do not have power.

Dissembling in the context of 'therapeutic' relationships can be viewed as paradoxical given that findings from the present study and other studies, such as Mind (2011) and Hardcastle et al (2007), suggest that what service users want is to be listened to. The importance of listening to the patient, allowing them to 'tell their story' rather than 'being asked questions that were irrelevant' to how they were feeling is demonstrated through the concepts in the grounded theory of pathogenic and salugenic relationships. 'Being listened to' is a core property in a salugenic relationship.

The present study provides data concerning deception by a health care professional. The health care professional resorted to using covert assessment of a patient through friendly 'chat' that undermined any potential trust developing in the relationship. Deception from either party in the relationship has negative consequences (Beste 2005). This was probably a well-intentioned attempt to 'help' a patient, however, the result was a damaged relationship because of reduced trust.

6.2.2 Lying and Self-Deception

Lying is defined by Ekman and O'Sullivan (2006) as the 'deliberate intention to mislead without prior notification of the target of the lie'. This is not the same definition used by the participants in the present study where the word lying referred to self-deception. Lewis, Stanger and Sullivan (1989) found signs in 3 year olds of deception. De Paulo et al, (1996) found that lies were common however, social interactions in which lies were told were less enjoyable. Self-concealment has been associated with negative well-being (Uysal, Lee Lin & Knee 2009). In a study on help-seeking behaviour, participants who were high self-concealers knew that they needed help but did not seek it (Cepeda-Benito & Short 1998). In an experiment with simulated conditions goal oriented 'self-presentation' was associated with more verbal deception (Feldman, Forrest & Happ 2002).

Summary

The discussion leads to the proposal that the dissemblance used by the participants was a contextual reaction to a 'medical context' as well as a growing self-awareness by the participants that they had lacked self-knowledge and self-awareness at the start of the study. However, the actual results of the outcome measures do not suggest that the dissemblance at the baseline assessment caused demonstrably reduced scores compared to subsequent scores.

6.2.3 Insider/Outsider Researcher

The researcher's stated position as a 'marginal native' or 'space-between' (see section 4.7.1) contributed to conflict and uncertainty. As Atkinson and Hammersley (2007: p.89) state, 'it contributes to a continual sense of insecurity'. However, stating the position of the researcher as an insider/outsider did not provide an adequate explanation of what was happening at the baseline interviews. Adopting

214

the position of the 'marginal native' or the 'space between' in this study was erroneous as it was not the researcher that determined the researcher's position but the participants. This is supported by Sayer's assertion that all research is 'value-laden' and therefore also supports the philosophical position outlined for this study of critical realism (see section 4.7.2). In the present study the conclusion is that the participants assigned the 'values' for the researcher's position.

6.3 Impact of Dissemblance on the Findings

A concurrent mixed methods study design was chosen in order to gather both outcome data and experiential data regarding the newcomers' experiences of Christ Church. In this section a discussion on the impact of contextual dissemblance on the quantitative and qualitative data is presented.

6.3.1 Mini International Neuropsychiatric Interview (M.I.N.I.)

The aim in conducting the M.I.N.I. interview was to provide a demographic of caseness, especially for newcomers who had not come from the mental health services. The benefit of using the M.I.N.I. is that there are questions designed to exclude medical causes that resulted in a broader approach to the study. The M.I.N.I. provided information on a participant with significant emotional distress from a medical condition.

The M.I.N.I. interview identifies both past and current diagnoses. The findings demonstrate that all newcomers, except one, had past and/or current diagnosable disorders. This finding was unanticipated based on prior assumptions concerning the demographic of existing Christ Church members. One inference that could be drawn is that the use of the diagnostic interview introduced type II errors consistent with Scheff's (1984: pp.79-81) proposal that when looking for mental illness it can be falsely found. However, further consideration of dissemblance leads to another conclusion. In the present study the participants stated reasons for dissembling concerned fear of mental health services and being sectioned. Therefore it is unlikely that the participants had overstated their mental distress. Another factor that suggests the M.I.N.I. interview data was truthful was that the diagnoses obtained from the interview were consistent with those that the participants had received in the past. The deduction leads to the proposal that dissembling was limited to the self-report measures.

6.3.2 Impact on Outcome Measure Results

The findings from the SCL-90-R demonstrate that the participants had not significantly dissembled in their responses. This was further supported by the combined use of the observer-report CGI and the self-report measures SCL-90-R and WHODAS-II suggesting that the dissemblance was small as there was general correlation between the scores. The only discrepancy was seen in one participant, F2, whose CGI scores consistently improved against the SCL-90-R that was more variable. This finding suggests that either the participant was unwilling or unaware of her improvement or that the functional outward improvement was not reflected in internal experience of improvement. There is no data to support either position. But the wider literature supports the view that people can be as averse to feelings of positive emotion as they are negative (Gilbert 2010: p.122) and that lack of conscious self-awareness is to be expected (Westen 1999).

6.3.3 Impact on Qualitative Data

The finding from the baseline assessments concerning dissembling was corroborated in the qualitative interview data concerning previous instances of dissembling with health care professionals. The participants described this as concealing, withholding and lying that became conceptualised as a theory of survival strategy. These data suggest consistency in their narrative that provided 'sensitising concepts' for the grounded theory. Without disclosure of dissembling the qualitative study may have taken a different direction.

6.4 Study Design Implications

Some of the design weaknesses could not have been predicted such as the small number of recruits and the resulting gender exclusiveness. Other implications involved the assumptions made at the start of the study. These were the choice of outcome measures, assuming a 'context independent' position in research and the approach to the consultation with existing members.

6.4.1 Implications for Choice of Outcome Measures

An assessment made using the CGI relies on all available evidence at the time of the assessment combined with the observers experience in the area of health

under study. From the findings there were a range of confounding factors including performing in order to present positive personal change. There was one instance of incongruence between the results of the CGI and the SCL-90-R (section 5.4.3). The assessment in the CGI suggested improvement over time that was contradicted by the scores on the SCL-90-R. This is an example of the usefulness of employing both types of outcome measure in order to overcome the weaknesses in both (Barker, Pistrang & Elliott 2002: p.109). The CGI provides an observer perspective on behaviour and the self-report measures provide the participants experience.

One conclusion from the apparently contradictory findings that the participants' declared positive personal change in interview data and lack of symptom improvement on the SCL-90-R is that of growing self-awareness. Westen (1999) proposes that the weakness with self-report measures is the person's inability to know themselves and their unconscious drives and motives that lead to not knowing how to respond to the questions. Although Derogatis (1994: pp.38-40) provides evidence that the SCL-90-R has performed well in psychotherapy outcome research. One conclusion is that the newcomers had demonstrated growing self-awareness and self-reflection such that instead of a decreasing 'symptomology' from lack of awareness, there was in fact a growing awareness of 'symptomology'. This needs to be interpreted in the understanding that the questions in the SCL-90-R appear quite general and unrelated to psychiatry. For example, 'How much were you distressed by feeling critical of others?' or 'How much were you distressed by blaming your self for things?'

Despite these general questions the participants still felt the measures were 'non-human'. This is supported by Rogers (1961: p.212) who proposes that the sciences and medicine tend to view the human organism as an 'object' and by Marcel (2010: p.13) who proposes that comparison between people makes self-consciousness worse and is a depersonalising process. He argues that the thing which gives a person real value cannot be judged by comparison. It can be inferred then that the participants were reacting negatively to the 'measuring' process rather than solely to the mental health services.

Self-report measures are designed to measure the experiences of subjects. The outcome measures in this study, whilst of themselves were appropriate choices for the sample, were inappropriate given the context. The reason for choosing these

measures was the assumption that measuring symptomology could be used as an indicator of improving or declining mental health. The SCL-90-R assessed symptomology, which is useful from a medical perspective but the findings suggest was incongruent with the participants' journey of growing self-awareness. Although designed as a symptom measure the 90-item questions do not always appear related to symptoms and therefore can be viewed independently. Taken out of context these questions can relate to aspects of self and relationships.

This study was designed with a two-year data collection period in order to capture change using outcome measures, which was assumed to occur over a longer period of time than a six-week or six-month study could demonstrate. This assumption may have been correct with the actual length of time to demonstrate symptomatic change for these participants being longer.

The value of outcome measures has been highlighted within therapeutic communities and is a current area of research by The Consortium of Therapeutic Communities (TCTC). Bonner and Luscombe (2008: p.69) suggested further research on outcome measures is required for the third sector. Morant and Manning (2005) state that psychological processes are difficult to quantify using self-report measures and particularly for therapeutic community settings that focus on psychodynamic, interpersonal and social contexts. The findings of a qualitative study to determine the views of service-users on outcome measures demonstrated that service users would like a non-clinical and more social approach to developing outcome measures (Perry & Gilbody 2009).

6.4.2 Implications for Church Related Outcome Measures

A review of the use of measures in researching spirituality and religion provides examples of 'closeness to God' measures, religious coping scales and motivation measures (Hill, Peter C. & Pargament 2003). A study measuring pastoral effectiveness (McKenna & Eckard 2009), proposed measures that were extracted from interview data. Other outcome studies have focused on church-based programs, that is to say programs run in a church setting but not the main purpose or focus of the church as a faith organisation (Peterson, Atwood & Yates 2002; Pickett-Schenk 2002). The findings from the present study support the use of a novel approach to measuring outcomes in Christ Church, similar to McKenna and

Eckard's (2009) study, in which the outcome measures emerge from the members and leadership of the church. Some of the existing measures may have been usefully applied in the Christ Church context but there are still some difficulties in constructs of religion and spirituality that require further investigation (Hill, Peter C. & Pargament 2003; Yanez et al. 2009). The findings from the present study research are supported by Roof's (2003) assertion that new methods are needed to address the issue of religious participation.

6.4.3 Implications for Defining Endpoints

Defining the endpoint of an outcome study is more complex in human research and made more complex by being church based study. The difficulty of defining an endpoint using outcome measures can be explained through research into well-being and quality of life. The concept of living well, which might include quality of life and well-being indicators, needs to be researched from the perspective of the individuals involved in the investigation. Within the context of well-being research, Ruini proposed that it was conceptually and methodological incorrect to assume that well-being was simply the absence of distress. Well-being was more complex than current measurements could address and suggested further research (2003). In another study participants described well-being as 'balanced', 'coping', 'stable', 'emotionally controlled'. For them well-being was not about being contented or happy all the time but about 'not letting things affect one's rationality' (Rogers, A. & Pilgrim 1997). These studies suggest that different approaches to defining endpoints need to be found. The difficulty of establishing endpoints in therapeutic community research was demonstrated from a meta-analysis (Lees, Manning & Rawlings 2004). The authors note that because of the wide range of treatments and length of treatments, there was no consistency in how and when to measures improvement. Given that Christ Church is not a treatment facility and has no defined length of stay this also adds to the difficulty in establishing endpoints, as there is no absolute endpoint. These studies have implications for the development of well-being outcome measures that are boarder than measures of happiness.

6.4.4 Implications of 'Value Neutral' Research

The conclusions on the researcher as an insider or outsider demonstrate that a 'value neutral' researcher in human research is not possible as the researcher is

not separate from the phenomena under observation. The researcher is part of the phenomena and therefore the context cannot be ignored. Instead a 'value laden' approach should be adopted that may result in qualitative research being conducted before quantitative research in order to highlight the preconceptions and values that may interfere with the research.

6.4.5 Participants Attitudes Towards Measures

The participants' attitudes to the outcome measures with regard to validity and 'lack of humanity' will have negatively impacted the results. It is not possible from the present study to determine the degree of influence this has had. However, the importance of belief in the measures had been emphasised by Derogatis (1994: p.6) concerning the SCL-90-R. He recommends that the interviewer should approach the interviews in a positive manner and interviewers who do not believe in the validity of the outcome measures should not conduct interviews. However, he makes no mention of the attitudes of the respondents. The test-retest validity of the SCL-90-R (Derogatis 1994) means that the retests performed in the study will not have been distorted.

6.4.6 Implications of the Consultation

One assumption was that the main concern of the existing members of the community would be the main concern of newcomers. During the consultation the existing members expressed their desire to be heard and taken seriously by the outside world. This desire is an interesting one, not addressed in this study. However, it has resonance in the newcomers concerns about the need to be listened to and taken seriously. But it resulted in an outcome study that was counter to the concerns of the newcomers. However, it can be deduced that the perspective of acculturated members was different to newcomers. This finding supports the view that attending to the main concerns of the newcomers was more important. The newcomers' priorities were demonstrated by the need to find relationship. The chosen outcome measures did not relate to the main concerns of the participants. For the newcomers the conditions of hope and safety along with mutual relationships were the important reason for joining Christ Church. These had significant benefits as described by them.

6.4.7 Implications for Christ Church

In the present study participants sought a non-medical approach to their recovery and healing. The implication of this finding for Christ Church concerns the impact of health and social work professionals within a church based therapeutic community and the use of professionals in the Christ Church Risk Management team. In the current study the Risk Management team was perceived by one participant as something to be fearful of and to be avoided. However, what is not evident from the data is whether this is fear of the professionals on the team or the team itself. This finding illustrates the uniqueness of Christ Church, which as a therapeutic community has structures and procedures in place to provide safety for all community members. However, at the same time this is an unusual dimension for a church. In a traditional church setting the professional status of members might not be salient and therefore carry the same impact on other members. This illustrates another aspect of the importance of context and the conflict that this can bring into Christ Church impacting on the safety and freedom of the environment.

These confounding factors support the conclusion that outcome measures congruent with the context of Christ Church as a church as well as therapeutic community are more likely to be congruent with the participants. For example, given the importance of hope in the ethos of Christ Church then using a measure of hope such as the Hope Scale (Snyder et al. 1991), may have more relevance. Although this does not have relevance to the existential hope that Marcel (2010: p.54) considers to be most significant and may also have been significant to the participants.

6.4.8 Implications of a Concurrent Design

Instead of a concurrent mixed methods design a sequential design beginning with qualitative data collection may have resulted in a different set of outcome measures chosen on the basis of the participants' concerns. These might have been less psychiatrically orientated and more directed towards hope, safety and relationships for example. However, this conclusion depends on similar content emerging from the qualitative data. Without the sensitising of the diagnostic interview and outcome measures the qualitative content may have been very different.

6.5 Summary

Contextual dissemblance demonstrated how the same researcher can represent two different contexts. Dissembling was declared to be as a result of fear of the researcher's occupation, mental health services and being sectioned, and self-deception This finding was supported by data from the qualitative interviews and later conceptualised into the grounded theory of incongruence and congruence that will be discussed in the next section.

The disclosure made by the participants suggests that trust had developed and therefore there was no reason to conclude that data from the qualitative interviews was the result of dissembling. The M.I.N.I. interview results were confirmed by previous mental health history. The CGI, SCL-90-R and WHODAS-II were broadly correlated in all but one case. Instead drawing on Westen's (1999) proposal that individuals are not aware of their unconscious drives, leads to inferring that the outcome measures chosen were incompatible with the participants 'journey' of personal positive change leading to increasing self-knowledge and self-awareness. This leads to discussing the grounded theory of incongruence and congruence.

6.6 Discussion of Qualitative Findings

The conditions for dissembling were conceptualised as pathogenic relationships and pathogenic emotions that induced a sense of incongruence with self, which means feeling disconnected, in disagreement, inauthentic. The converse situation is found with salugenic relationships and emotions that can facilitate congruence with self. Congruence is defined as agreement, harmony and authenticity.

6.7 Losing Self through Incongruence

The present study conceptualises the loss of self through the impact of pathogenic emotion and pathogenic relationships. The loss of self is described as fragmented, shrivelled, and living in unreality. Incongruence with emotions occurs through pathogenic emotion, which is emotion that is denied, repressed or overwhelming. Emotion becomes harmful (or pathogenic) through not being connected to cognition, not being expressed and is primarily experienced as negative. Pathogenic emotion can be a barrier to forming positive relationships and can be

intensified by pathogenic relationships through re-shaming and fear. The self withdraws from emotion and other people.

6.7.1 Pathogenic Emotion

The concept of pathogenic emotion is supported by Lane's (2006) proposal that unprocessed negative affect is a 'pathogenic response to environmental stress' and that 'self-concealers' are associated with having a negative sense of well-being (Uysal, Lee Lin & Knee 2009). Undischarged emotion becomes pathogenic in posttraumatic stress disorder (Yehuda, Rachel 2001; van der Kolk 2006) and that unexpressed negative emotion has a direct effect on the immune system increasing the likelihood of infections (Cohen & Wills 1985; Cohen, Tyrrell & Smith 1991; Pennebaker, Kiecolt-Glaser & Glaser 1988). The present study does not provide evidence for a causal link between pathogenic emotion and mental illness but offers a possible theory through the concepts of loss of self and incongruence. Pathogenic emotion differs from the term 'negative emotion' by clarifying that all emotion can be experienced as either positive or negative, that is to say it is valenced and therefore evaluative. The experience of negative emotion is part of being human, as confirmed by the research into well-being (Ruini et al. 2003). It is what a person does or does not do with emotion that results in it becoming salugenic or pathogenic. Pathogenic emotion is emotion that is incongruent through becoming separated from cognition and therefore separated from self-awareness. 'Emotions are central to mental and social life because they are fundamental mediators between inner and outer worlds' (Oatley 2001: p.xviii) and a loss of emotional connectivity may lead to loss of a coherent sense of self. The inability or unwillingness to label or express emotion can be detrimental to therapy outcomes (Boritz et al. 2011), and result in an inability to meet one's own needs (van der Kolk 2006).

Emotional dysregulation is viewed as a core symptom in posttraumatic stress disorder (Cloitre et al. 2012: p.4). Allan Schore (2008) has discussed the significance of emotional dysregulation on the negative development of the self. In work situations that require 'emotional labour' (presenting a positive and cheerful appearance in customer service) having to be discordant with one's own emotions led to burn-out (Mesmer-Magnus, DeChurch & Wax 2012). In *Beyond The Therapeutic Community*, Maxwell Jones suggests that having to conform to

society and repress emotions inhibited 'social learning'. 'To deny to such an extent the free expression of feeling is to limit the opportunity for social learning' (1968: p.71). Two emotions in particular emerged from these qualitative data that were fear and shame.

Fear

There are two layers of fear; overt layer is that of fearing the mental health services and their power and the underlying fear of exposing shame. It is proposed that both fears are significant and determine behaviour although shame is often the hidden drive. In the present study the fear of health services emerged from explicit description in the data whereas underlying fear of exposure emerged as 'overt-undifferentiated' shame from analysis.

The emergence of fear in relation to mental health services in the present study is supported by studies and research on fear presented in chapter one. Fear of mental health services is associated with fear of madness (Keating & Robertson 2004; Bassett, Sperlinger & Freeman 2009) and fear of coercion (Swartz, Swanson & Hannon 2003). The definition of fear used in the current study is that of Rachman's (1978: p.56) felt insufficiency of one's own power (or an excess of the other's power). In a more general study the delay in help seeking was considered to be due to fear and negative imaging (Safer et al. 1979). Fear is a normal emotion, however, excessive fear and anxiety may increase stress and therefore increase the vulnerability to mental illness as described in the Mental Health Foundation report *In the Face of Fear* (2009). This report was a response to the increasing amount of anxiety and fear in the general population, although Furedi disputes this (Mental Health Foundation 2009). The report states that only 25% of people with mental health problems are in treatment compared to 90% of people with physical illness. This number is reduced in people with mixed anxiety/depression to 15%. The presence of fear can result in failure to seek help compounding the problem.

Shame

Incongruence theory conceptualises the way in which shame is pathogenic. Pathogenic emotion is trapped emotion that is not expressed or overwhelming emotion. Shame drives behaviour such as isolating, withdrawing from others, and losing self through feelings of worthlessness, powerlessness and coping mechanisms such as alcohol misuse.

224

Fear of exposure along with concealing and lying are proposed in the current study as evidence for 'overt-undifferentiated' shame. Concealing and lying is conceptualised as part of the survival strategy to minimise fear and shame, and protect the self from further pain. This is related to self-deception discussed below. Pathogenic shame is linked with physical ill-health (McCauley et al. 1998; Dickerson 2004) mental illness (Candea & Szentagotai 2013), such as, depression (Andrews, Qian & Valentine 2002; Luby et al. 2009), posttraumatic stress disorder (PTSD) (Andrews et al. 2000; Feiring 2005; Wong, M. R. & Cook 1992; Leskela, Dieperink & Thuras 2002; van der Kolk 2001), suicide (Lester 1997, 1998; Mokros 1995), anxiety (Van Vliet 2011), and alcohol and drug abuse (Dearing, Stuewig & Tangney 2005; Meehan et al. 1996). It is also associated with less help-seeking (Scheff 1988; Vogel, Wester & Larson 2007). Shame is proposed as a reason for the lack of effectiveness of more traditional types of cognitive behaviour therapy (CBT) (Stott 2007; Gilbert 2010).

Altrows (2006) grounded theory researched 'overt shame', which enabled direct associations to be drawn from her data between shame and the consequences of shame. In the current study shame was mostly 'overt-differentiated'; some may have been 'by-passed' but this was impossible to deduce without attention to non-verbal and detailed analysis of sentence timings and repetitiveness (Lewis, H. B. 1971). Pathogenic shame resulted in using a survival strategy for the similar reasons to Altrows' (2006: pp.87-9) withdrawal and avoidance behaviours used to avoid the pain of the shame experience and included turning to alcohol and overeating.

The theory of incongruence conceptualises a relationship between shame and power in which the shamed person who had an inherent sense of worthlessness and powerlessness feels more shame from a pathogenic relationship.

Shame and Faith

Findings from the current study demonstrate that participants joined Christ Church to find relationships and support. Seeking relationships is the antidote to shame and seeking within a church context also implies seeking reconciliation with God. This is supported by Altrows (2006: p.89) research in which participants isolated themselves from people and disconnected from God or a 'Higher Power' as a

225

result of shame. One of her participants stopped praying because she believed she was too awful to stand before God. Her participants described how reconnecting with God or a Higher power helped healing from their shame through finding acceptance from God and through social connection in practicing their faith. Pattison (2000: p.279) suggests that the church finds shamed people 'unproblematic and useful to the wielders of ecclesiastical power and authority'. The church can become a place of shame when dogma and belief transcends the individual's need for love and acceptance (Martin, D. 1968: pp.183-84). The current study does not have findings which support these proposals.

In Christ Church the culture is non-medical language, non-diagnosing and non-comparative which normalises mental illness through the narrative process. In mental health research there is the focus on stigma rather than shame as a barrier to help-seeking. In the Sainsbury Centre (2010) report on *Looking Ahead* in Mental Health most of the contributors hoped to see a reduction in stigma as a result of mental illness no longer being a taboo subject. Whilst it is important to reduce stigmatisation this present study does not focus on stigma, as it did not emerge in the data.

6.7.2 Pathogenic Relationships

The findings in the present study demonstrate that hidden shame can be significant by preventing the formation of therapeutic relationships. The theory of incongruence conceptualises these relationships as having the potential to be pathogenic or harmful. Pathogenic relationships have the potential to reinforce negative emotion. Pathogenic relationships have the property of actual or perceived power inequality that was demonstrated in four contexts, with the researcher, church, parents and mental health.

The researcher

The researcher has been discussed in the section on contextual dissemblance. However, in relation to the grounded theory the researcher's occupation as a mental health professional combined with the psychiatric assessments provoked incongruence through an implied pathogenic relationship with properties of unequal power, judgement, loss of trust and heightened shame and fear. This provides an illustration of the use of 'pathogenic' as the potential to generate harm.

Church

The present study provides data on the use of power in church relationships. For example, being asked to leave a Christian organisation due to mental illness and the perception that the church was protecting its own reputation from the emotional illness of a staff member was shame inducing. This resulted in feelings of worthlessness and powerlessness and for one participant doubting her faith in God. When the church is a place of rigid rules and belief, it does not have the capacity to accommodate people who are both chaotic and emotionally and mentally fragile (Martin, D. 1968: p.181).

Pattison (2000: p.199) writes that some churches find it easier to focus on guilt because church leaders can remain in control by being able to do something such as offering absolution. He suggests that choosing to focus on shame could lead to church leaders themselves feeling powerless and feeling ashamed.

'Religious struggles' that can include difficulties with congregational relationships, friends and family and doubts about God are associated with increased in mortality (Pargament et al. 2001). For example, viewing illness as the 'work of the devil' or 'God's abandonment' characterises internal conflict that illness brings resulting in the need to reappraise one's beliefs.

Parents

Pathogenic relationship was demonstrated through the abuse of power by parents. Michael Lewis (1992: p.114) comments on power in parenting by using the expression 'power assertion'. 'Power assertion' can be illustrated by the phrase "You will do it because I tell you so". He proposes that this produces shame through the 'intensity of the stimulus' that results in the inability of the child to focus to the meaning behind the message. It can be deduced that power assertion was something that happened for the participant who described how her parents had not explained her medical condition to her. In this instance the changes to her life will not have been explained but rather asserted.

Mental health

Pathogenic relationships in the mental health services are characterised by power inequality. In a review of the literature on trust, choice and power, Laugharne and Priebe (2006) identified three areas of power relevant to mental health services.

They are 'state power', 'power balance' and 'empowerment of the patient'. The findings in this grounded theory study provides data for all three areas. For example, with regard to 'state power' the participants expressed their fears about being sectioned and about mental health services. This illustrates the significance of the unique power to involuntarily detain someone under the Mental Health Act that had damaging consequences on trust. The second area is the importance of 'power balance' in relationships between doctors and patients. The health system has been described as inherently resisting client power and compares the relatively weak power of the client compared with the stronger power of the health professionals in the system (McCubbin & Cohen 1996; Beste 2005; Laugharne, Richard & Priebe 2006; Hardcastle et al. 2007). Power inequality can be demonstrated through the discussion on coercion (Rogers, A. 1993; Wertheimer 1993; Hannigan & Cutcliffe 2001) and the fear that this induces (Swartz, Swanson & Hannon 2003). This problem can be accentuated by emotive language used by anti-psychiatry and anti-psychopharmacology that does not help to progress a meaningful dialogue about how to develop patient empowerment (McCubbin & Cohen 1996). However, the health service does not have to be pathogenic if proactive measures are taken to minimise the impact of power imbalance on the therapeutic relationship (Cushing 2003). Empowerment in the present study is found with regard to autonomy in section 5.14.6.

6.7.3 Survival Strategy

The finding from the baseline assessments of dissembling was corroborated by the data for the grounded theory, which generated a theory of the motivations behind the self-confessed lying and concealing. These were identified and conceptualised in the theory as a survival strategy made up of deceiving, performing, blaming and manipulating.

Dissembling can occur as a result of shame and the use of safety behaviours (Gilbert 2010: p.68).The reason for the participants to choose survival strategy over disengagement was not evident. However, there are two possible reasons that emerge from the literature. The first possibility is that this is a consequence of shame. There are recognised safety behaviours, behaviour strategies or coping styles, employed to minimise the impact of shame. Scheff (2000) suggests that as shamed children grow-up they adopt two behaviour strategies either to seek power (bypassed shame) or become passive (overt-undifferentiated shame). Pattison

(2000: p.120) identified how he used both strategies at different times. The main response being to withdraw, submit and admit defeat (Altrows 2006). Andrews (2000) also related shame to submission and defeat in a physical assault. Gilbert (1997) suggests five possible responses; counter-attack, submit but carry revenge, seek out others (alliances), refer to a higher authority, for example, God who knows that I am good, and finally feel disgusted or hateful towards self. He also suggests avoiding relationships or controlling social attention through limiting exposure and concealment (Gilbert 1997).

The second explanation that would fit the analysis is a consequence of fear. The concept of controllability was described by Rachman (1978: pp.7-11) as a cognitive strategy to minimise the fear of threat. In the present theory the threat is perceived to be the pathogenic relationship and its consequences. The more a person is able to or thinks they can control a situation the less fear is experienced. However, 'the absence of perceived control in a potentially aversive condition generates fear' (Rachman 1978: p.9). One conclusion is that both explanations are accurate and applicable to the theory given that fear and shame are both salient emotions in the present study.

Summary

The theory of incongruence offers an explanation for the contextual dissemblance through the concepts of pathogenic relationship and emotion. These concepts provided an explanation of the participants' reaction to the researcher and the baseline assessments by proposing that they were reacting to the mental health context which in the past had been pathogenic for them. They were incongruent with the medical model of mental health care. The theory suggests a process of losing self as a consequence. The findings do not provide explicit details, but it can be inferred from the subsequent openness with the researcher that pathogenic relationships can be overcome. The process by which this may occur is discussed in the next section.

6.8 Finding Self through Congruence

Finding self depended on others helping the person out of their survival strategy by offering different choices. Offering choice increases autonomy and 'affirms efficacy and power (Pattison 2000: p.308). The theory of losing and finding self

developed an integrated concept of self through emotions, cognitions, social, cultural and spiritual components. All of these aspects were congruent for the newcomers in Christ Church which facilitated finding self. However, some participants also described good relationships with their current health professionals, but there was not enough data to describe them as salugenic.

6.8.1 Salugenic Relationships

Salugenic relationships are characterised by openness and transparency as opposed to deceiving and performing that are used in the survival strategy. This means openness and transparency in communication with others rather than hiding and being isolated. Other properties are reciprocal listening and reciprocal acceptance within the context of safety and freedom which results in connectedness, not just with one or two others but also with the whole community through shared goals. The findings of the present study, like Altrows' (2006: p.93-5)(*ibid*: p.93-5), demonstrate that connecting with other people is a part of the process of rebuilding the self.

As introduced in chapter one and further defined in chapter four, the definition of congruence is a dynamic process of finding more agreement and harmony and forms a core part of the salugenic relationship outcome. Congruence in the present study also includes belief. In psychotherapy there is an extensive literature on congruence. Congruence is one of the three therapist's conditions, the other two being empathy and unconditional positive regard which underpin effective therapeutic relationships (Rogers 1957; Gelso, C. J. & Carter 1994; Hubble, Duncan & Miller 2000a; Kolden et al. 2011). In the current study empathy can be inferred from comments on finding other people with similar experiences, other people who understand. Data to support unconditional positive regard can be found from the categories of feeling accepted and non-judgemental relationships. Rogers' (1961: p.61) definition of congruence is 'being open to the emotions and attitudes flowing in him' and a sense of being real not a façade. In other words it means having self-conscious self-awareness of one's feelings.

Gelso (2009) proposes that the 'real' relationship incorporates realism of perception/experience and genuineness of expression. He concludes this falls short of a wider meaning of 'real' relationship by proposing that there is more than

genuiness and realism and suggests more research should be carried out. In the current theory the key factors were de-contextualising the relationship, feeling known, and mutuality. Gelso's concept of a 'real' relationship supports the concept of salugenic congruent relationship through the data that describes them as being connected to something real.

De-contextualising

One helpful concept emerging from salugenic relationships is that taking the relationship out of the 'therapy room' enables positive power to develop and resists negative power struggles. This has also been identified by a grounded theory study conducted in the context of the Kids Company (Lemma 2010). The organisation works with traumatised children and young people in London. The research found that young people did not value the scheduled appointments with therapists but valued the conversations and everyday chats that occurred spontaneously 'in the corridors' and buildings. Lemma suggests that these chats reduced the sense of power inequality that pre-arranged appointments carried. Fear of the consequences of self-disclosure was a reason for not seeking out emotionally supportive relationships (Rogers, A. & Pilgrim 1997). This was not just related to power inequality but also includes the general risks of becoming open and transparent with another person. Research from service users and health professionals also found that issues of treating patients with humanity, commissioning of people's needs, choice and control and reducing the medical emphasis within acute care by using a person-centered approach (Mind 2011: pp.6-7). The Schizophrenia Commission Report (2012) identified that schizophrenics were being let down by 'anti-therapeutic ward environments'.

The salugenic relationships in Christ Church resemble friends and family support rather than professional which is supported by evidence from research on the views of 'lay people' with regard to mental health (Rogers, A. & Pilgrim 1997). The study found that incongruence can be inherent in the relationships between 'lay persons' and professionals through professionals using individualistic approaches to treatment over social ones, which is contrary to the beliefs of the 'lay persons' (Rogers, A. & Pilgrim 1997). Rogers and Pilgrim go on to say that mutually agreeable partnerships could be achieved if this gap were bridged (*op.cit*). The theory of salugenic relationships is supported by their findings that concluded that those who had their own problems but were receptive to the needs of others

'would make better lay counselors than those seen as being psychologically strong' (Rogers, A. & Pilgrim 1997).

The World Health Organization report states that people with mental health problems especially depression are less likely to go to their general practitioner (GP) (*ibid* p.9). These studies also include data suggesting that overall people prefer to approach friends and/or relatives for support during these times (Horvitz 1978; Oliver et al. 2005). This is confirmed by the finding in the data that 100% of newcomers to the community already had friends as members. This suggests the participants had already reached a 'tipping point' in terms of trusting the community. This is in sharp contrast to their experiences of trusting the health services. Potentially people may have come to the community as an alternative to seeking traditional help.

Feeling known

The salugenic relationship is characterised by discovering that 'I am not the only one'. This solidarity with another person generates a powerful feeling of belonging and understanding. This has been described by Stern as 'intersubjective contact' which is the interpenetration of minds that allows us to say 'I know that you know that I know' or 'I feel that you feel that I feel' (2004: p.75) defined as the 'present moment of a lived story' (*ibid* p.55). Goleman describes the result of an I-You encounter, 'At such moments we sense that the other person knows how we feel and so we feel known' (2006: p.107). This is the essence of relationship that is missing in a pathogenic relationship. For persons with emotional and mental difficulties who have not been understood, an encounter that helps the self to feel known leads to hope, belonging, feeling accepted that enables trust to begin developing with others. These in turn lead to courage to begin reflecting on self and becoming more self-aware through choosing transparency and openness in relationships.

The need to feel listened to emerged as a key concern that is also recognised in therapeutic community literature. Hinshelwood (1987: p.83) wrote 'That is a particularly poignant despair- when a belief exists that there is nobody there to understand the sense of there being nobody there' and 'what man seeks most deeply is emotional contact with his fellow human beings' (Symington 1986: p.238).

Mutuality

The property of mutuality in salugenic relationships is the antidote to power inequality. This was demonstrated through dyadic relationships and within the culture of Christ Church. For Anglin (2002: p.101-2) reciprocity, which he defines as mutuality, was a core property of the struggle for congruence in residential children's homes. In a study about relationships between nurses and their patients, two common factors identified as a 'tipping-point' for establishing a therapeutic relationship were trust and power-sharing (Welch 2005). These factors were subsumed under the definition of mutuality.

Power sharing is the antidote to unequal power and therapeutic communities offer power sharing through democratisation as one of the core values (Rapoport 1960; Haigh 1999; The Consortium for Therapeutic Communities 2012). Main (1989) writes about the psychiatrist's role in a therapeutic community. He states that the psychiatrist must become a member of the real community where he no longer 'owns his patients' and where his role is be a technician among rather than a superintendent of his patients (*ibid*: p.9).

In the wider literature the desire for mutuality has been shown to be conditional on the severity of the medical crisis, where in serious medical illness, such as cancer, (Mechanic & Meyer 2000) and a crisis in mental illness (Laugharne, R. et al. 2011) the patient requires that the professional assumes authority. This leads to inferring that power balance and mutuality can be contextually dependent.

6.8.2 Salugenic Emotion

Salugenic emotion is not defined as positive emotion such as happiness, joy and love. Instead it is healthy emotion that is connected, expressed, valenced and contagious and contributes to a unified sense of self. This is demonstrated in the present study through self-awareness and self-reflection concerning emotion and its impact on behaviour and relationships. This concept is supported by the definition of emotional-social intelligence:

> 'emotional-social intelligence is a cross-section of interrelated emotional and social competencies, skills and facilitators that determine how effectively we understand and express ourselves, understand others and relate with them, and cope with daily demands' (Bar-On 2006).

Salugenic emotion is also supported by research on posttraumatic growth in which it is hypothesised that emotional intelligence moderates emotional expression such that it is appropriate and effective (Linley et al. 2011). The findings show that emotional intelligence moderates emotional expression in men but not women, which led the authors to conclude that further research was required on the outcome measures chosen. The other finding is that emotional expression and emotional intelligence facilitate posttraumatic growth. This is also supported by Ruini et al's (2003) findings that people expected to be able to feel all kinds of emotion as a definition of well-being, but not be overwhelmed by them.

Hope

The theory of salugenic emotion provided the concept that finding hope was an important determinant in joining and remaining in Christ Church. Hope was contagious. The ethos of hope and believing in the hope that others have was a significant factor in attracting the newcomers to join Christ Church and in the formation of salugenic relationships. What was not conclusive was the type of hope, that is to say, 'hope for' a specific change in self or the wider 'hope in' God. It is reasonable to infer that both were significant given that hope in God is the basis of faith. However, the significance of 'finding hope' in the current study is supported by Holmes' (2004: p.222) description of a core value in Christ Church that is to learn hope from others.

Richard Laugharne and Stefan Priebe (2011) found that patients valued their clinicians being positive about the future. In Christ Church this was explicitly called hope and it referred to the values and meanings of hope for them that included faith. This has been identified by Lemma (2010) who found that these relationships were powerful in reinforcing the importance of hope on the recovery process. For Bloom and Farragher (2013: p.67) the role of the therapist is as the 'hope-keeper's' for their clients. The goal orientated approach to hope supports one aspect of the hope in the present study (Snyder, Michael & Cheavens 2000). The findings demonstrate the generation of hope through listening to other people's stories and mentoring that suggests the development of hope related goals for their own healing. For Marcel (2010: p.52) 'hope is always associated with a communion' so that he suggests despair and isolation are identical. He suggests that there can be no hope without the temptation to despair (*ibid*: p.30) and hope means 'accepting the trial as an integral part of self' (*ibid*: p.33). The importance of

hope in finding more of self is supported by Marcel's statements through the concepts of being accepted by others and developing self-reflection and self-awareness. Whilst hope is viewed as a core belief in the Christian faith and is also a goal of psychotherapy it is not a core principle in therapeutic communities. This is one area in the present theory of salugenic emotion that distinguishes Christ Church from other therapeutic communities.

6.8.3 Implications of Salugenic Relationships and Emotions

The implications of the theory of salugenic emotions for Christ Church involve helping members to be able to remove the 'social stain of shame' (Pattison 2000: p.84) whilst at the same time holding onto a healthy 'respect shame' that keeps boundaries of behaviour in place. 'Respect shame' is inherent in the Christian faith that emphasises the honour and respect of God and other people. Pattison goes on to propose that the church needs to identify ways to help integrate people and facilitate a sense of worth (*ibid*: p.308-9).

Whilst therapeutic community research does not address shame directly, the core principles of therapeutic communities and the emphasis on the social-relational can be seen as the potential opportunity for the removal of stigma and shame.

The theory of pathogenic shame proposes that shame was a hidden drive in the behaviour of participants in pathogenic relationships. The implication of this finding for health care and churches is to become aware of the impact of shame on relationships and to minimise inadvertent shaming of individuals. Churches have the innate opportunity to maintain healthy 'respect' shame whilst facilitating the removal of 'disgrace shame' and stigma. However, Resnick (1997) cautions not to view shame as the root cause of all psychopathology.

Summary
Salugenic emotion is emotion that is congruent with beliefs, relationships and self through connecting self-awareness and cognition. Salugenic relationships facilitate salugenic emotion and can therefore facilitate congruence and finding more of self.

6.8.4 Finding More of Self

Congruence with self is demonstrated through contextual congruence, that is to say belief. These beliefs are in God, the therapeutic community model of church and the *Rapha* model of discipleship. These beliefs provided the conditions of hope and safety supported by the actions of members, most specifically mentors. The relationships facilitated more hope enabling the newcomer to internalise hope for themselves and begin to experience positive personal change. This process addressed different areas in which the self develops spiritually, culturally, socially, cognitively and emotionally. Despite some participants' issues with religion and church all participants had some form of faith in God. As Anglin (2002: p.103) suggests 'full congruence' is an ideal and is a more appropriate to use the term degrees of congruence. Self-identity includes a sense of coherence that is subsumed under the concept of congruence. Being able to make a coherent sense of self in terms of the autobiographical self, is an essential part of healing and journeying toward well-being (Eriksson & Lindstrom 2006; Siegel 2012). The theory of finding more of self is supported by Joseph and Linley's (2006) goal that growth-focused rather than illness-focused therapy should be considered for 'recovery from adversity'. This requires development of 'client centered, experiential, existential therapies of value in the facilitation of growth'. This is supported by Holmes' (2004: p.178) findings on the journey of wholeness as a concept of change and Williams' (2007: p.133) findings on Christ Church as a 'change-enabling atmosphere that facilitates 'empowered change'. In adopting a view of self that is inclusive the following definition is useful;

> 'an evolving biopsychosocial system forged through the alchemy of emotion, thought, motivation, biology, action, relationships and the sociocultural context' (Altrows 2006)

Social Self

The drive for social connection can be framed within Daniel Stern's (2004) theory of interpersonal psychotherapy, which emphasises the theory of finding self through interaction. The concept of the development of the social self is supported by Trevarthen (2009) who proposes that the theory of intersubjectivity is the framework to understand 'emotional 'moral' regulations of human community' where there are 'feelings of relatedness' to others and shared meanings that determine individual self-worth. Stern posits the theory that 'intersubjective

236

orientation' is needed to 'define, maintain or re-establish self-identity and self-cohesion, to make contact with ourselves. We need the eyes of others to form and hold ourselves together' (*ibid* p.107). When self-identity is threatened we can dip into the 'intersubjective matrix', which Stern describes as a 'continuous cocreating dialogue with other minds' (*ibid* p.77) to prevent 'self-dissolution or fragmentation' (*ibid* p.111). However, high levels self-consciousness associated with pathogenic shame may result in the feeling of being subsumed by another and actually reinforce fragmentation and self-dissolution. For example, phrases typified as shame, 'I wish the ground would open up and swallow me' and 'I died of shame'. Therefore, whilst agreeing with Stern's initial proposition, as demonstrated by Schore (2002) this 'intersubjective matrix' must be conditional on salugenic relationships otherwise it can be inferred that it may not always helpful. It requires attentive, care giving, loving relationships to prevent the fragmentation of the self (Schore, A. N. 2002; Schore, J. R. & Schore 2008; Trevarthen 2009, 2010). The theory of finding more of self is supported by a study demonstrating that one of the main ways of maintaining mental health was striving for autonomy, which was carried out in two ways, drawing on inner reserves for coping and using support and positive feedback from others (Rogers, A. & Pilgrim 1997). Joseph and Linley (2006: p.144) propose that 'individuals are intrinsically motivated to cognitively accommodate their psychological experiences under the right social environmental conditions'.

Social and Cultural Self

In the current study congruence facilitated belonging. Belonging is defined as the 'drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships' (Baumeister & Leary 1995: p.497), which is a narrower definition than the one emerging from congruence theory. In the context of a therapeutic faith community the meaning of belonging extends further than social relationships, it also includes, sense of meaning, purpose and belief. For some this includes the broadest sense of belonging that of belonging to the wider family of God.

Belonging is a core therapeutic community principle but can reach a deeper level in a church setting where length of membership is generally self-determined. The importance of a sense of belonging for the participants is supported by literature proposing that belonging has a strong impact on the sense of self (Walton et al.

237

2012). As described in chapter one belonging and social support has been widely reported as beneficial for health, resilience and recovery. Putnam (2000) presents the benefit of being socially connected, not just superficial connections but connections made from commitment to and belonging to groups or organisations. He writes, 'Joiners become more tolerant, less cynical, and more empathetic to the misfortunes of others' (*ibid* p.288).

In Park's (2005) proposal for a model of religion as a meaning-making system, the author suggests that individuals acquire their meaning-making systems from the wider culture and religious institutions who provide support and the structure within which individuals behave and turn to in crisis. But in using these meaning-making systems the individuals also create and maintain them.

Spiritual self

Congruence theory suggests that religious belief is not individualised in this study and supports Day's (2009) findings that belief is associated with belonging. The theory of salugenic congruence infers that the embedded nature of salugenic relationships in the beliefs and values of Christ Church were attractive to the newcomers and at the time of the study they were congruent with these beliefs and values. Research into resilience, the capacity to adapt in the face of adversity, suggests that having a sense of purpose and a framework of beliefs are important factors in resilience (Feder, Nestler & Charney 2009).The findings show that the participants' definition of spirituality included a sense of meaning, purpose and of being human. This is supported by Martsolf and Mickley (1998) and Cook's (2004) definitions chosen for the current study. However, further research is needed in this area in order to develop a deeper understanding of the need for social connection alongside a belief in God that facilitates the sense of being human.

In research examining the meaning in life and posttraumatic growth, Linley and Joseph (2011) researched groups of churchgoers, funeral directors and the general population. They distinguished between the presence of meaning and the search for meaning and found that the presence of meaning was associated with positive change and the search for meaning was associated with negative change. This is supported by the research on religious struggles (Pargament et al. 2001; McConnell et al. 2006). Also supporting this research are the findings in a systematic review of the associations between religion, spirituality and

238

posttraumatic growth (Shaw, Joseph & Linley 2005). The review's main findings are that religion and spirituality, and in particular positive religious coping, are usually beneficial for posttraumatic growth and that traumatic experiences can lead to deepening religion and spirituality. The author's conclude that therapists need to be respectful of clients' religious and spiritual beliefs because they are important and therapeutically relevant.

Emotional Self

The theory of salugenic emotions proposes that salugenic relationships provided safety and freedom to 'discover unknown elements of self' through 'the experience of feeling' (Rogers 1961: p.111). For Rogers these were dyadic therapeutic relationships, but in Christ Church all relationships have the potential to facilitate congruence between emotion self and others and culture. Human beings, have an innate ability to read the environment emotionally and this can inform thought and behaviour. A 'shared representation model' proposes that humans have the ability to perceive emotion in another that activates the neural networks of emotion in the self (Decety & Chaminade 2003). This self-other interaction is the basis for self-development.

The importance of emotional regulation and health is described in the literature in neurodevelopmental psychotherapy (Schore, J. R. & Schore 2008), in psychology (Pennebaker & Seagal 1999), and psychiatry (Lane 2006, 2008). In addition emotion regulation is an important factor in developing resilience (Feder, Nestler & Charney 2009). In patients with cancer focusing on and venting emotions, social support and active coping were all factors that contributed to posttraumatic growth (Morris, Shakespeare-Finch & Scott 2007).

Authenticity

The interrelatedness of the development of self to the social is expanded to include the emotional, cognitive, cultural and spiritual through the literature on authenticity. The concept of a congruent self that emerged in the present study is supported by a definition of authenticity:

> 'The authentic person possesses the following: awareness of and motivation to know one's goals, feelings and self-beliefs, even if contradictory; unbiased processing of one's attributes, emotions, experiences and knowledge; behavior in

accord with one's personal needs, desires and values; and a relational orientation toward honesty and openness with others' (Kernis & Goldman 2006).

Authenticity has also been defined as a disposition towards self-congruent behaviour and positioned the research within a social context (Lenton et al. 2013). In addition authenticity is recognised to be emotionally felt (Sheldon et al. 1997; Vannini & Franzese 2008). Authenticity in nursing was said to be 'as close as could be found to using the total self for therapeutic ends' (Welch 2005: p.164).

Authenticity and Uniqueness

Although Scheff (1988) proposes that shame is used for conformity in society, within Christ Church there is a different dynamic described by Williams (2002: p.44). Within Christ Church there is a 'community of diversity' where the 'focus of Christ Church's social identity was personal identity', and where personal identity is valued above the communal. This is borne out in the present study where belonging within conditions of safety and freedom enabled participants to begin finding more of self. This is supported by self-verification theory (Swann, W. B., Jr., Milton & Polzer 2000; Swann, W. B. et al. 2003), which suggests that self-verification made group members feel like individuals. The feeling of verification (or acceptance) accounts for why they felt more connected to and identified with their group. Brewer's (1991) work in particular developed the concept of optimal distinctiveness theory (ODT), which is a model of how an individual manages the conflict between being different from others whilst at the same time needing to be similar to them. The need to belong is as important as the need to be different or unique. The goal is to avoid the real pain of social rejection (Kross et al. 2011). ODT itself draws from research in the field of social identity theory and makes the distinction between social identity (which is not simply group membership but a chosen identity) from individual identity because the 'I' becomes 'we'. What is proposed is that each chosen social identity becomes in itself a frame of reference for the self-concept. In research focusing on the cultural aspects of self-concept, Markus and Kitayama (2010) have proposed that the influence of culture on the self is mutual, in that the self can influence culture in the same way that culture influences self.

Openness and self-disclosure enables a concept of self to become clearer, more definable because of the uniqueness of the autobiography. It also reveals more of

the sameness and differentness from others that Jourard (1971: p.205) identifies as also contributing to a sense of belonging. A conclusion that can be drawn from this is that an intact sense of self-awareness and self-concept develop alongside healthy socialisation.

6.8.5 Congruence with Beliefs

The implication of contextual dissemblance on the choice of outcome measures can be discussed with respect to congruence theory. The present study demonstrates that the participants were incongruent with the baseline assessments through being incongruent with the medical model. They expressed this in questioning the validity of the measures and defining them as non-human. Therefore other outcome measures that are congruent with the context of a church-based therapeutic community would have been more useful.

Psychotherapy research demonstrates that outcomes have less to do with the therapeutic or psychoanalytic technique employed and that 40% of the outcome is accounted for by the patient/client factors (Hubble, Duncan & Miller 2000b: p.9). These factors include client's faith, social support and sense of personal responsibility. For nurses attending to their own values and beliefs, described as congruence, was important in being able to form therapeutic relationships with their patients (Welch 2005).

Congruence theory is supported by the proposal that congruence needs to be framed by a network of beliefs and values (Greenberg & Geller 2001: p.149). In psychotherapy this is stated as congruence that is embedded in the three conditions of the therapist summarised by 'do no harm' (*ibid*). For Christ Church these beliefs and values are located in the Christian faith, biblical principles and the *Rapha* model and are summed up in the Christ Church mission statement of 'Loving God, Loving people'. This is supported by the finding that having a structured belief system has a positive effect on psychological health (Shaw, Joseph & Linley 2005) and having meaning and purpose in life are predictors of adjustment to cancer (Yanez et al. 2009). Although if the structured belief system is a source of strain then it can be associated with depression and suicidality (Exline, Yali & Sanderson 2000). The literature presents the view that finding religion and spirituality a source of comfort and positive coping is beneficial to

health but unresolved conflict and tension such as doubting and tension can have the opposite effect. The current study does not offer any added evidence for cause and effect in this regard, but offers a theory that finding self involved being congruent with the beliefs in the Christ Church. This is supported by Holmes' (2005: p.216) proposal to add one other core value to the 'quintessence' of therapeutic core values (Haigh 1999) that is 'with Christ in our midst'.

For the participants in this study the *Rapha* model and Christ Church provided congruent beliefs. However, as stated congruence is not an absolute: it is better described as degrees of congruence. The present study does not provide evidence of degrees of congruence for a salugenic effect. This is a complex area described by Chaves (2010) as 'religious congruence fallacy' and requires further research.

Colombo et al (2003) identified that conflicting models of mental health are currently in use in the mental health services multidisciplinary team. This leads to conflict, inefficiency and ineffectiveness. These findings demonstrate an implicit difference in what is defined as 'therapeutic'. Within psychoanalysis the therapeutic relationship has been researched for many years assuming it to be the most essential component in successful therapy outcome. Whereas the medical model has tended towards emphasising evidence based treatments such as medication or psychological therapies. Colombo et al (2003) identified other models of mental illness such as sociological and family derived. This leads to proposing that in the present study the participants are expressing opinion and experiences of two different models and highlighting their incongruence with the medical model and congruence with the Christ Church model. This is not the same as dismissing the medical model as 'bad' as there are examples of trustworthy and supportive mental health professionals. Examples of salugenic relationships may be found in many contexts, but for the participants in the current study many of these examples are found in Christ Church.

A distinction needs to be drawn here between relationships found in therapeutic communities and those in the mental health services and health services generally. In therapeutic communities relationships are prioritised as the key to healing, they are two-way, mutual and reciprocal. In therapeutic communities and in Christ Church there is the belief that everyone can learn about themselves

through their relationships with others. In the health service this is not a basic premise instead the onus is on the health professional to establish a rapport and to maintain a professional relationship that can also be therapeutic. This demonstrates the differences between the two models and the expectations towards both models. This distinction makes it clear that some people will be congruent with a medical model because this style of relationship suits them or their situation.

Research demonstrates that within mental health services the efficacy of pharmacotherapy depends on the person's belief and trust in the doctor and in the medication (Luparello et al. 1970; McKay, Imel & Wampold 2006). This is supported by Stern (2004: p.179) who wrote, in the context of the therapist:patient relationship, that the patient learns trust in the process and the therapist learns to trust the patient's ways of doing things, so together 'they are both cocreating ways-of-being-with-one-another'.

6.9 Summary

The main finding is that the holistic approach found in Christ Church offers support and healing to those for whom other services have not been beneficial or have not been sought, and who specifically want a faith framework to their recovery and healing. Where powerlessness and lack of social support have been identified as key risk factors for mental illness (Fitzsimons & Fuller 2002), Christ Church offers both empowerment and social support. The theory of salugenic relationship is a broader concept than therapeutic relationship and includes mutuality, facilitating hope and congruence, and is situated within community context.

By taking a conceptual approach congruence theory brings balance to the experiences of the participants, through suggesting that incongruence and congruence of belief is at the core of the research findings. This integration led to the theories of incongruence and congruence. The theory of congruence involves emotional, cognitive, social, cultural and spiritual awareness and integration involving the self in relationships with others. It is not the same as the absence of distress or being happy. A congruent individual has the capacity to feel all the emotions of life as a human being, which include loss, fear and pain along with happiness and hope, and is equipped in how to manage those emotions and learn

from them. The theory of congruence demonstrates the process through which individuals find more facilitated by congruent relationships and environment.

6.10 Validity of Congruence Theory

The validity of the grounded theory is based in its grounding in the data and systematic analysis. The data in general was not biased for or against the health services as positive and negative examples were given. The data concerning Christ Church did not focus on the positives, but included the negatives as well such as difficulty joining the community.

A grounded theory is evaluated through fit, work, relevance and modifiability (Glaser 1978; Glaser & Strauss 1967). The theory of incongruence and congruence 'fits' the substantive data rather than any preconceived ideas or frameworks. Reading the wider literature was carried out after the analysis was complete and not before. It is 'workable' in that the theory has sufficient power to explain what was happening in the area under study. The theory is also well supported by the wider literature on the importance of relationships, social connection, emotion and beliefs. The theory of salugenic relationships expands the existing understanding of therapeutic relationships to incorporate mutuality, hope, trust and openness. The theory on pathogenic and salugenic religion is supported by the wider literature on spirituality and mental health. The 'relevance' of participants' positive change that occurred over time leads to concluding that salugenic relationships and salugenic emotions have benefited the newcomers. It is the combination of salugenic relationships and congruence that provides the holistic conditions to facilitate personal positive change. The 'relevance' of this is to research on health outcomes, well-being and resilience in health services, therapeutic communities and church contexts. 'Modification' of the theory occurred throughout the analysis through not discarding data and using sampling help integrate the theory. In addition, the theories of incongruence and congruence are not definitive but open to be modified by future research. For instance, the importance of a personal faith in God did not emerge from these data, but the theory can be modified to include this data in the future.

The aim of using grounded theory to develop a theory of what was happening was met through the emergence of the theories of incongruence and congruence.

These theories have sufficient explanatory power for the area under study through providing a theory on dissembling in the baseline assessments. The limitations of grounded theory are in producing theoretical frameworks that are probabilities and make no claim for evidence. Thus the relationship between pathogenic relationships and pathogenic emotion has been conceptualised and a next step would be to test causality.

The grounded theory of pathogenic incongruence and salugenic congruence has been discussed in the wider literature and is limited by data in the present study. The wider implications have not been researched and therefore the theories are open to be modified by future research.

7 Conclusions

The primary aim of the current study was to establish if there were any health benefits to belonging to a therapeutic faith community. The findings from the outcome measures chosen did not provide evidence for or against. This was partly due to the small sample size and to the assumption that measuring symptomology was a way to establish benefit. The conclusion of this study is that measuring health outcomes from a therapeutic faith community proved too complex for measures that were derived from therapeutic community and mental health research. However, positive changes were identified that included reduction in medication, discharge from secondary mental health care, returning to work and study. Other positive changes were found in qualitative data included removal of shame, finding hope, spirituality, authenticity and uniqueness that help to distinguish Christ Church from other therapeutic communities and churches.

The focus on emotional healing in Christ Church probably resulted in the data on emotion being salient. This is an aspect of Christ Church that also distinguishes it from other therapeutic communities and churches. These factors can be used in future research and also in helping Christ Church to position itself with regard to other therapeutic communities and churches. The present study was designed on the basis of Christ Church as a therapeutic faith community but it is not an archetype therapeutic community.

The secondary aims of the study were:
- To determine who benefits
- What members perceive as important in the therapeutic community
- The importance of social factors compared to therapeutic factors
- Whether belief influences the perceived benefit to belonging to the community and what the belief is in.

The results from the M.I.N.I. diagnostic interview demonstrate that all the newcomers, with one exception, had diagnosable mental and emotional disorder. This is supported by the SCL-90-R that demonstrated evidence for 'caseness' for all participants. Findings demonstrate that Christ Church appeals to women who

have previous experience of mental health services and current mental health issues. The study does not provide evidence with regard to men.

The participants all stated that finding relationships was the reason for joining Christ Church. They made no distinction between Christ Church as a church and as a therapeutic community. It was clear that both aspects were important reasons for joining. A conclusion is that Christ Church although applying the core values of a therapeutic community also has other core values which make it unique.

The conclusion from the findings is that there is no distinction between the social and the therapeutic factors in Christ Church. These were considered to be the same. Belonging, finding safety and freedom and hope were socially facilitated and therapeutic for the newcomers who were able to develop congruence with themselves. Finding more of self from wider literature would suggest greater wellbeing. In the study 'therapeutic relationship' was redefined as salugenic relationship and one of the important factors concerned the situating of salugenic relationships within the salugenic wider context.

The conclusion of the study is that congruence with belief is important with regard to the decision to join Christ Church. These beliefs are related to the church, therapeutic community model and *Rapha* discipleship model of emotional healing. Incongruence with the 'medical model' of mental illness was a factor for some in seeking help from Christ Church. The medical model is associated with not being treated as a human being. Whereas belief in God gave meaning and purpose to the value of the 'discipleship journey' through finding the core of being human that is synonymous with finding more of self.

In contrast to the dehumanisation that occurs as a result of pathogenic relationships and emotions, and incongruence of beliefs, a conclusion is that congruence theory proposes a rehumanising process occurring as a result of finding congruence with self through others, which also impacts other areas of life including congruence with faith and with treatment beliefs. In many ways congruence can be different for everybody, in as much as some prefer the use of medication and others prefer talking therapy.

Incongruence and congruence theory add to the previous understanding of congruence in psychotherapy by demonstrating that context is an important consideration for the therapeutic relationship. Decontexualising the relationship was beneficial in reducing power inequality and fear associated with that. Therefore congruence can be achieved in many relationships in Christ Church because the relationships support the culture and the culture supports the relationships. Congruence was achieved in Christ Church because it was different to the medical model and it included the Christian beliefs that were important to the participants.

In his postscript to *Descartes' Error*, Damasio (1994: p.256) remarks on the growth of alternative medicine as a result of dissatisfaction with traditional medicine's inability to consider the human being as a whole. He predicts that this will intensify with a growing spiritual crisis in Western Society. In taking a holistic view he suggests that the goal of human beings is to remind ourselves and others of our complexity, fragility, finiteness and uniqueness, '…to remove the spirit from its nowhere pedestal to a somewhere place, while preserving its dignity and importance …' (*ibid* p.252). Congruence theory demonstrates the importance of like-mindedness. Like-mindedness is found in the relationships in Christ Church amongst lay-people, who are 'experts by experience', whose qualifications are through experience and are characterised by mutuality. Salugenic relationships that facilitate rehumanisation through taking the holistic view provide a 'somewhere place for the spirit' that is congruent for members of Christ Church. The theory of congruence seeks to break down the barriers towards personal recovery by first identifying those barriers. It demonstrates the process that enables an individual to progress towards personal congruence through relationships and environment.

7.1 Limitations and Future Research

The limitations of the present study were the small sample size and female sample. Therefore future research can apply the theoretical frameworks developed in the current study to a mixed gender, larger sample to establish if the theory 'fits' 'works' and is 'relevant' for a male and female sample.

Participants' stated beneficial changes such as, the value of relationships, self-reflection, self-awareness and hope increased were not directly measured. Other concepts emerging from the grounded theory, also not measured, were finding a place of safety and belonging with supportive salugenic relationships. It is these aspects of change that produced benefits, despite the measures of symptomology. This finding requires further research. In outcome research defining endpoints is important. In Christ Church there is the need for future research to define what kind of positive change is it that outcome measures could quantify.

A limitation of this study was in being able to conceptualise salugenic congruence and pathogenic incongruence. Further expansion of the theory of salugenic congruent theory is necessary in order to distinguish between what constitutes salugenic and pathogenic congruent beliefs. For instance, a pathogenic congruent belief may be that experienced by someone in a psychotic episode.

The study adds to the concept of congruence by suggesting that mutuality, openness and transparency are essential characteristics that provide a framework for future research. This is in contrast to the deception and self-deception demonstrated in the first part of the analysis and conceptualised as incongruence. It would have been interesting to research whether conducting the diagnostic interview after the outcome measure may have produced different results.

The complexity of some risk issues that occurred in Christ Church has resulted in the appointment of a Risk Management team. However, one conclusion is that this team is associated with fear and power of the mental health services. This is an issue that requires further research. It is not evident from the study whether this is fear of the professionals on the Risk Management team or of the team itself.

In developing this theory it is also apparent that barriers exist between different services and sectors. These barriers can be broken down through developing ways of communicating research and best practice. Further research needs to be carried out to determine ways of minimising the impact of pathogenic relationships and emotions in the health services through understanding the process of incongruence.

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Appendices

Appendix II

CLINICAL GLOBAL IMPRESSIONS (CGI)

Patient Information

Patient		Date	Day	Mth.	Year	Time	Hour	Min

Personal notes

1. Severity of Illness

Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?

- ☐ Normal, not at al1 ill
- ☐ Borderline mentally ill
- ☐ Mildly ill
- ☐ Moderately ill
- ☐ Markedly ill
- ☐ Severely ill
- ☐ Among the most extremely ill patients

2. Global Improvement

Rate total improvement whether or not in your judgment it is due entirely to drug treatment. Compared to his condition at admission to the project, how much has he changed?

- ☐ Very much improved
- ☐ Much improved
- ☐ Minimally improved
- ☐ No change
- ☐ Minimally worse
- ☐ Much worse
- ☐ Very much worse

3. Efficacy Index

	None	Do not significantly interfere with patient's functioning	Significantly interfere with patient's functioning	Outweigh therapeutic effect
Therapeutic effect	**1**	**2**	**3**	**4**
4. Marked Vast improvement. Complete or nearly complete remission of all symptoms	4.00	2.00	1.33	1.00
3. Moderate Decided improvement. Partial remission of symptoms.	3.00	1.50	1.00	0.75
2. Minimal Slight improvement which doesn't alter status of care of patient	2.00	1.00	0.67	0.50
1. Unchanged or Worse	1.00	0.50	0.33	0.25

Appendix III

World Health Organization
Disability Assessment Schedule II

Phase 2 Field Trials – Health Services Research
36-Item Self-Administered Version

H1	How do you rate your <u>overall health in the past 30 days</u>?	Very good	Good	Moderate	Bad	Very Bad

This questionnaire asks about <u>difficulties due to health conditions</u>. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the <u>last 30 days</u> and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only <u>one</u> response.

In the last <u>30 days</u>, how much <u>difficulty</u> did you have in:					
<u>Understanding and communicating</u>					
D1.1	<u>Concentrating</u> on doing something for <u>ten minutes</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D1.2	<u>Remembering</u> to do <u>important things</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D1.3	<u>Analyzing and finding solutions to problems</u> in day to day life?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D1.4	<u>Learning</u> a <u>new task</u>, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D1.5	<u>Generally understanding</u> what people say?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D1.6	<u>Starting and maintaining</u> a <u>conversation</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
<u>Getting around</u>					
D2.1	<u>Standing</u> for <u>long periods</u> such as <u>30 minutes</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D2.2	<u>Standing up</u> from sitting down?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D2.3	<u>Moving</u> around <u>inside your home</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D2.4	<u>Getting out</u> of your <u>home</u>?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D2.5	<u>Walking a long distance</u> such as a <u>kilometre</u> (or equivalent)?	None	Mild	Moderate	Severe	Extreme/ Cannot Do

Please continue to the next page …

In the last 30 days, how much difficulty did you have in:					
	Self Care				
D3.1	Washing your whole body?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D3.2	Getting dressed?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D3.3	Eating?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D3.4	Staying by yourself for a few days?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
	Getting along with people				
D4.1	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D4.2	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D4.3	Getting along with people who are close to you?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D4.4	Making new friends?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D4.5	Sexual activities?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
	Life activities				
D5.1	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.2	Doing most important household tasks well?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.3	Getting all the household work done that you needed to do?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.4	Getting your household work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme/ Cannot Do

IF YOU WORK (PAID, NON-PAID, SELF EMPLOYED) OR GO TO SCHOOL, COMPLETE QUESTIONS D5.5-D5.8 BELOW. OTHERWISE, SKIP TO D6.1 AT THE TOP OF THE NEXT PAGE.

	In the last 30 days, how much difficulty did you have in:					
D5.5	Your day to day work/school?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.6	Doing your most important work/school tasks well?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.7	Getting all the work done that you need to do?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D5.8	Getting your work done as quickly as needed?	None	Mild	Moderate	Severe	Extreme/ Cannot Do

Please continue to the next page …

	In the last <u>30 days</u>:					
	<u>Participation in Society</u>					
D6.1	How much of a problem did you have in <u>joining in community activities</u> (for example, festivities, religious or other activities) in the same way as anyone else can	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.2	How much of a problem did you have because of <u>barriers or hindrances</u> in the world around you?	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.3	How much of a problem did you have <u>living with dignity</u> because of the attitudes and actions of others	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.4	How much <u>time</u> did <u>you</u> spend on your health condition, or its consequences	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.5	How much have <u>you</u> been <u>emotionally affected</u> by your health condition	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.6	How much has your health been a <u>drain on the financial resources</u> of you or your family	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.7	How much of a problem did your <u>family</u> have because of your health problems	None	Mild	Moderate	Severe	Extreme/ Cannot Do
D6.8	How much of a problem did you have in doing things <u>by yourself</u> for <u>relaxation or pleasure</u>	None	Mild	Moderate	Severe	Extreme/ Cannot Do

		Not at all	Mildly	Moderately	Severely	Extremely
H2	Overall, how much did these difficulties <u>interfere</u> with your life?	Not at all	Mildly	Moderately	Severely	Extremely
H3	Overall, in the past 30 days, <u>how many days</u> were these difficulties present?	RECORD NUMBER OF DAYS ___/___				
H4	In the past 30 days, for how many days were you <u>totally unable</u> to carry out your usual activities or work because of any health condition?	RECORD NUMBER OF DAYS ___/___				
H5	In the past 30 days, not counting the days that you were totally unable, for how many days did you <u>cut back</u> or <u>reduce</u> your usual activities or work because of any health condition?	RECORD NUMBER OF DAYS ___/___				

This completes the questionnaire. Thank you.

Appendix IV

SCL-90-R

Not included due to copyright

Appendix V

CONFIDENTIAL
NEWCOMERS QUESTIONNAIRE
SEPTEMBER 2006

Thank you for agreeing to help me with my PhD research into the potential health benefits of living in Christ Church.

This is a short questionnaire to find out information about you and your lifestyle.

There are also a few questions about your views and opinions which I hope you will be able to answer as honestly and openly as you can. Feel free to answer what you can and to write as much as you like.

The questionnaire should not take more than half an hour to complete. Do not hesitate to contact me if you need help. Ruth Brown, Tel. ██████████

General Information

1. Age……………………………..

2. Gender ☐ M ☐ F

3. Marital status
   ☐ Single
   ☐ Single, previously married
   ☐ Married
   ☐ Other, please

   specify…………

   ……………………………………………………………………………………………………

   ……….…………………………………………………………………………………………

   ……......

4. Children – do you have any? ☐ Yes ☐ No
   If YES, how

many……………...............

5. Ethnic origin
   ☐ White
   ☐ Asian
   ☐ Black
   ☐ Mixed race

☐ Other, please specify…………

…………………………………………………………………………………………

…

<table>
<tr><td colspan="2" align="center">**Education**</td></tr>
</table>

6. **Education – what qualifications did you leave school with?**

   ☐ **O'levels**   **How many?**...

   ☐ **GCSE's**   **How many?**...

   ☐ **A'levels**   **How many?**... ☐ **Other**

      Please specify…………………………………………………………..

7. **Do you have any further education, e.g. Access course, NVQ's, HND's BTEC etc.? Please specify**…………………………………………………………….

   …………………………………………………………………………………………

   ….

8. **Do you have any graduate or**   ☐ **Yes**   ☐ **No**
   post-graduate qualifications?
   If YES, please specify…………………………………………………………..

   …………………………………………………………………………………………

   …

   …………………………………………………………………………………………

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<table>
<tr><td colspan="2" align="center">**Employment**</td></tr>
</table>

9. **What is your current employment**   ☐   **Full-time, paid**
   employment
   status?   ☐   **Part-time, paid**
   employment

                                            ☐   **Full-time education**
                                            ☐   **Voluntary work**
                                            ☐   **Retired**

☐   **Not working**

If not working, please specify why

....

....

....

....

If not working, when did you last have paid employment?....................................

10. Are you currently receiving   ☐   **Unemployment**

       state benefits?   ☐   **Incapacity benefit**

         ☐   **Other(s) Please**

specify.........

....

....

....

Health

11. In terms of your general physical health, how would you rate your current health?

☐	☐	☐	☐	☐
Very good	**good**	**average**	**poor**	**very poor**

12. In terms of your general mental/emotional health, how would you rate your current health?

☐	☐	☐	☐	☐
Very good	**good**	**average**	**poor**	**very poor**

13. In terms of well-being, how would you rate your current well-being?

☐	☐	☐	☐	☐
Very good	**good**	**average**	**poor**	**very poor**

14. Do you have a current mental or emotional illness?   ☐Yes   ☐ No

     If YES, Are you receiving any professional help?   ☐ Yes☐ No

     If YES, What kind of help?...

……………………………………………………………………………………………
…

Are you taking any medication for it?   ☐ Yes ☐ No

If YES, how long have you been taking

it?………………………………………………………………

……………………………………………………………………………………………
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This is additional space for you to provide any other details you

wish……………………………………………………………………………

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15. **Do you have a current physical illness?**   ☐ Yes ☐ No

    If YES, are you receiving any professional help for this? ☐ Yes ☐ No

    What kind of professional

help?……………………………………………………………………

    Are you taking any medication for this illness?   ☐ Yes ☐ No

    If YES, How long have you been taking it

for?……………………………………………………

    There is space here for you to provide any other information you would like.

……………………………………………………………………………………………

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16. **Do you smoke?**   ☐ Yes ☐ No

17. **Do you have a current problem with addictions?** ☐ No addictions

                                                        ☐ Alcohol

                                                        ☐ Drugs

                                                        ☐ Other, please

specify…….

....
...

If Yes, please answer the following questions:

How long have you had this addiction?..

....
...

How does it affect your daily life?...

....
...

....
...

What help are you currently receiving for this?...

....
...

....
...

18. How many times have you visited your G.P. in the last six months?....................

19. How often do you have a dental check-up? ☐ 6 monthly

☐ 12 monthly

☐ Other, please specify......

....
...

20. Have you had any hospital admissions in   ☐ Yes☐ No
the last 3 years?

If NO, please go to question 20

If YES, please give brief details, including approximate dates……………………

....
...

....
...

21. How would you rate your experience in hospital?

☐   ☐   ☐   ☐   ☐

excellent   good   OK   poor   awful

22. This is extra space if you would like to provide more details…………………………………………………………………………
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23. What do you understand by the term 'looking after your body ?
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…………………………………………………………………………
…………....

24. In what ways do you look after your body?..
…………………………………………………………………………
…………………………………………………………………………
……

Social

25. Do you own your own home?   ☐   Yes   ☐ No

    If NO, Have you owned your own home in the past?   ☐   Yes   ☐ No

26. What kind of accommodation do you live in?   ☐ on your own - rented

Home ☐ on your own - own

☐ sharing with a family
☐ sharing with singles
☐ other, please

specify……...

…………………………………………………………………………………………

….

27. Before joining Christ Church, on average, how many times a week did you meet the following?

Friends…………………………………………………………………………………

…..

Family……………………………………………………………………………………

…...

Attend social

events………………………………………………………………………..

Other, please

specify…………………………………………………………………….

28. Do you have any hobbies or interests? ☐ Yes ☐

No

If YES, please

specify……………………………………………………………….

Christ Church

29. How did you hear about the community? ☐ Friends
☐ Family
☐ Books
☐ Films
☐ Other, please

specify…

………………………………………………………………………………………

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………………………………………………………………………………………

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30. Have you attended any Rapha workshops? ☐ Yes ☐ No

If YES, how many and approximately how long

ago?...

……………………………………………………………………………………………………
…

……………………………………………………………………………………………………
…

If NO, have you had any sessions with ☐ Yes ☐ No
either Peter or Susan?

31. Did you move to the area to join Christ Church? ☐ Yes ☐ No

32. If yes, how easy did you find it to move here?

☐	☐	☐	☐	☐
very easy	easy	alright	hard	very hard

Please give brief reasons for your

answer……………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

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33. What factors influenced your decision to join Christ

Church?.................................

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…

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…

Could you pick out one word which would sum-up this

decision?........................

34. Did you visit the community before deciding to join? ☐ Yes ☐ No

If YES, how helpful was the visit?

☐	☐	☐	☐	☐
very helpful	helpful	OK	unhelpful	very unhelpful

Please give reasons for your

response……………………………………………………

……………………………………………………………………………………………………
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35. **Have you any suggestions for how Christ Church can help improve the moving process?**………………………………………………………………………
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36. **Have you been attending a church in the**   ☐ Yes   ☐ No
   last six months?
   If YES, how long have you been attending this
church?...
   If NO, do you have any church or religious background? ☐ Yes   ☐ No

37. **What do you understand by the term 'therapeutic faith community'?**...................

……………………………………………………………………………………………………
…

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38. **What do you understand by the word 'spiritual'?**..

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39. **Would you describe yourself as a spiritual person?** ☐ Yes ☐ No

Please give reasons for this

answer…………………………………………………………

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40. **What benefits do you think Christ Church has for**

you?..

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41. **What do you think might be the disadvantages of Christ Church for**

you?..
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42. **Even at this early stage, please may I ask have you considered how long you might remain as a member of the community?..**

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Thank you very Much for your time and help. All answers are in complete confidence. If you have any further comments I would be delighted to receive them. If you have any questions about this research please contact me.

Appendix VI

Chair of KREAG
KIMHS
University of Kent
Kent Research and Development Centre
Canterbury
CT2 7PD

September 4ᵗʰ 2007

Dear Sir,

Re. Mrs Cathrin Ann <u>Ruth</u> Brown

On behalf of the Trustees of Christ Church Deal, I am writing to inform you that we have given Ruth permission to conduct research on members of the community as part of her PhD in accordance with the protocol.

Yours faithfully,

Martin Carnall
Chair of Trustees, Christ Church, Deal

evangelical alliance
uniting to change society

"I am the mender, the one who sews you together, into Christ" (e.g Exodus 15:26)

Biblical discipleship • A Christ-centred wholeness journey • Diagnostic counselling • Authentic faith community

KENT
UNIVERSITY OF KENT

Kent Institute of Medicine and Health Sciences

Mark G Brennan
Head of the Division of Clinical Education

Tel: 01227 824080
Fax: 01227 824054
Email: M.G.Brennan@kent.ac.uk
www.kent.ac.uk

Ms CAR Brown
2 Clim Down
Kingsdown
Kent
CT14 8EX

08 June 2007

Dear Ruth

Re: Your submission to the KIMHS Research Ethics Advisory Group (KREAG)

Thank you for your submission to the KIMHS Ethical Approval Group, regarding your project entitled *The Health Benefits of Living in an Open Therapeutic Community.*

First of all, the committee would like to congratulate you on an excellent and comprehensive application for ethical approval.

Upon reviewing the application, the committee requested that a letter of approval should be obtained from the trustees of the charity risk management committee.

I would be grateful if this could be obtained as soon as possible and sent to Louise Bullock, Departmental Administrator, at the above address. It will then be presented to the committee at their next meeting. In the meantime, I see no reason why you should not proceed with your research, and I wish you well with this project.

Please do not hesitate to contact me if you have any queries.

Yours sincerely

P. P.

Mark G Brennan,
Chair of KREAG

c.c Professor Tony Hale, Professor Cornelius Katona

Appendix VIII

Information sheet for a research study
Kent Institute of Medical and Health Sciences
University of Kent

Title of research: A study into the health benefits of living in an open therapeutic community.

Researcher: Ruth Brown

Phone number: ███████████

- This study is designed to determine if living in an open therapeutic community affects health.

- All newcomers to the community will be asked to participate. The study will last for around two years.

- In order for this study to be meaningful to organisations that plan and fund healthcare, all participants will be interviewed using standard clinical assessments. The first interview is to assess you to see if you would qualify for a diagnosis. If you meet one of the criteria for a diagnosis, you will be informed and the implications of this will be discussed. This interview should take around 30 minutes.

- At this first interview you will be given a questionnaire to fill in. This should take about 30 minutes. The questionnaire will be asking you, for example, about your previous use of the medical services and how well you have felt in the last few months.

- All information about you will be kept confidential.

- This study will also be collecting information about how the community functions at a socially.

- Other clinical assessments or rating scales will be used to assess physical, mental, social functioning. These assessments should take around 45 minutes.

- You may be asked to participate in an interview about your expectations of the community and how it might benefit you. This interview may take around one and a half hours and will be tape-recorded. This interview will be repeated in one years time to show any changes in your thoughts and ideas about the community.

- Before you decide to take part or not, please take time to consider your decision and discuss this with someone you trust. If you choose not to participate it will not adversely affect your time here in the community.

- If you decide to take part you will be asked to complete a consent form.

- You have the right to withdraw from the study at any time.

Consent Form

Consent to participate in a research study
Kent Institute of Medical and Health Sciences
University of Kent

Title of research : A study into the health benefits of living in an open therapeutic community.

Researcher: Ruth Brown

Phone number: ███████████

I have read and understood the information leaflet given to me by Ruth Brown.

Participation in this study will be for two years.

During this study, I understand that I will be asked to fill in a general questionnaire and other questionnaires about my health. I will also be interviewed about my mental health and may be given a diagnosis as a result. I understand that if I take part in the interviews, then they will be tape-recorded.

I understand that I may withdraw at anytime from the research and this will not affect my involvement in the community.

I understand that all information provided will be treated with confidentiality. This means that my name will be on the questionnaires, but my name will not be entered onto any computer or appear in any research findings. The named research results will not be passed onto any other party. The tape-recorded interviews will be treated confidentially and will be destroyed following the publication of this PhD.

Participant

I agree to participate in this research and I will receive a copy of this consent form

Name……………………………………………….. **Date** ……………

Researcher

I have explained to the above named participant about the research as well as the potential benefits and risks of participating in it. I have answered the questions of this participant. I will provide a copy of the consent form.

Name …………………………………………….. **Date**

Fear

Fearing Relationship

Fear of people

Fear of exposure

Fear of knowing that others do not want to talk to her

Fear of not knowing what to say

Fear of connecting with people

Fearing Exposure

Fear of exposure

Fear of feeling judged

Anxiety prior to interview

Fear the consequences of the disclosure

Fear of the consequences of the disclosure on our relationship

Fear of not being helped

Fear of Self

Fear of being wrong

Fear of suddenly losing the plot

Fear of being called a fraud

Fear of consequences of being believed

Fear of Power and Authority

Fear of authorities

Fear of being forcibly treated

Fear the community will have her sectioned

Fear of mental health services

Fear of being in hospital

Fear of professional's power

Fear of being sectioned

Fear of rejection

Fear of being discarded

Fear of not being believed

Fear of not being helped

Fear of being called a fraud

Expressing concern about time running out

Fear of change

Fear of Change

Fear of Change not lasting

Fear of unknown

Fear of Responsibility

Fear of God Stuff

Fear of Madness

Fear of suddenly losing the plot

Fear the consequences of the disclosure

Fear of the consequences of the disclosure on our relationship

Fears Realised

Exposure of fear

Feels falsely accused

Blames doctor for problems

Loss of control

Failure of staff to treat her as a professional

Previous trust in doctor broken by collusion

Tau not enough

Perceiving judgment from professionals

Feeling that what she wants to say is worthless

Tests are not real world

Loss of hope in God

Powerlessness of situation on the ward rounds

Professionals catch you out

Being offered treatments that gave no hope of change

Deceived by health professionals

Categorising others and self

Collusion between professionals

Not believing the professionals

Feels only been asked what staff want to hear

Feels falsely accused

Crass advice is a barrier to therapeutic relationship

Feel worthless blamed and essentially flawed

No establishment of rapport from staff

Feeling trapped

Treatment is dependent upon interview

Feeling Shame

Fearing the consequences of that disclosure on our relationship

Feel worthless blamed and essentially flawed

Fearing the consequences of the disclosure

Fear of being called a fraud

Fear of exposure

Fear of not knowing what to say

Fear of being wrong

Not wanting to be a bother

Fear of not being believed

Fear of consequences of being believed

Not being taken seriously

Fear of knowing that others do not want to talk to her

Feels falsely accused

Self-judgment

Enemy to them

Perceiving judgment from professionals

Them and us

Lack of understanding and reassurance from staff

Loss of trust

Previous trust in doctors broken by collusion

Collusion between professionals

Feeling as though being tested

Feeling judged

Tests are not real world

Being misunderstood results in barriers in relationship

Trapped by Fear and Hopelessness

Accepting illness equals hopelessness

Hopelessness in an unchanging situation

Believing that positive change was too hard or impossible

Treatment is dependent upon interview

Not knowing how to be helped

Resigned to situation

Lost hope in the system

Institution not safe

Wanting others to save her

Feeling trapped

Being offered treatments which gave no hope of change

Tau not enough

Desperate for some hope or life

Blames doctors for problems

Risking disclosure resulted in not being heard my needs are not being met

Lack of understanding and reassurance from staff

Impossibility of the situation

Loss of Trust

Loss of trust

Explaining difficulty with paid staff

Tests are not real world

Crass advice is a barrier to therapeutic relationship

Collusion between professionals

Institution not safe

Explaining the difficulty with paid staff

Fearing the consequences of that disclosure on our relationship

Lack of understanding and reassurance from staff

Previous trust in doctor broken by collusion

Being misunderstood results in barriers in relationship

Deceived by health professional

Choosing to live carefully

Them and us

Failure from staff to treat her as a professional

Feeling as though being tested

Feeling caught out

Questioning validity of the questionnaires

No establishment of rapport from staff

Perceiving judgment from professionals

Not Being Heard

Feel worthless blamed and essentially flawed

My needs are not being met

Feeling judged

Feeling that what she wants to say is worthless

No establishment of rapport from staff

Feels only been asked what staff want to hear

Self-judgment

Being misunderstood results in barriers in relationship

Risking disclosure resulted in not being heard

Not being taken seriously

Reaching out for relationship through humour

Deceiving

Anxiety prior to interview

Presentation of self as a performance

Dichotomy between speech and feelings

Understanding of how to play along

Manipulating the system

Exerting control

Looking for someone to collude with her self-deception

Intentional withholding of truth

Intentional lying in interview

Blaming

Feels only been asked what staff want to hear

Refusal to comply with ward routine

Blames one person for not being able to trust the community

My needs are not being met

Excusing full commitment to the community

Blames doctor for problems

Feeling Judged

Not being taken seriously

Failure from staff to treat her as a professional

Perceiving judgment from professionals

Crass advice s a barrier to therapeutic relationship

Not being taken seriously

Feeling as though being tested

Feels falsely accused

Them and us

Fearing the consequences of that disclosure on the relationship

Fearing the consequences of the disclosure

Feeling powerless in situation

Professionals catch you out

Tests are not very human

Not Safe Place

Loss of trust

Lost hope in the system

No sense of belonging

Feeling judged

Presentation of self as a performance

Feels falsely accused

Blames one person for not being able to trust the community

Institution not safe

Difficulty with emotions

Feeling caught out

Powerlessness

Understanding of how to play along

Perceiving judgment from professionals

Hopelessness in an unchanging situation

Feeling powerless in situation

Collusion between professionals

Exerting control

Accepting illness equals hopelessness

Overwhelming panic

Loss of control

Powerlessness of situation on ward rounds

Manipulating and Controlling

Judging others

Exerting control

Looking for someone else to collude with self-deception

Loss of control

Refusal to comply with ward routine

Categorising others and self

Manipulating the system

Wanting others to save her

Understanding of how to play along

Being denied choice

Ability to function practically

Choosing to live carefully

Intentional lying in interview

Trying to be my own saviour

Loss of Hope

Loss of hope in God

Believing that positive change was too hard or impossible

Ups and downs are hard

Feeling powerless in situation

Expressing concern about time running out

Accepting illness equals hopelessness

Perceiving judgment from professionals

Powerlessness of situation on ward rounds

Tau not enough

Not believing in permanent positive change

Extremity of her life at this point

Being denied choice

Not found what she was looking for

Being offered treatments that gave no hope of change

Hopelessness of an unchanging situation

Lost hope in the system

Impossibility of situation

Feeling trapped

Worthlessness

Feeling that what she wants to say is worthless

Tests are not very human

Felt worthless blamed and essentially flawed

Not wanting to be a bother

Lack of confidence

Being denied choice

Others not wanting to talk to her

Feels only been asked what staff want to hear

Losing Self

Self-judgement

Lack of confidence

Self-deception

Dichotomy between speech and feelings

Loss of hope in God

Difficulty with emotions

Categorising others and self

Not knowing how to be helped

Depression makes it hard to communicate with strangers

Choosing unreality

No sense of belonging

Perceiving judgment from professionals

Being denied choice

Presentation of self as performance

Tests are not very human

Isolation

Excusing full commitment to the community

Depression makes her want to withdraw

Superficial relationships are easy

Making relationships is hard

Admitting that self-judgment and self-hate are producing relationship difficulties

Community not a safe place

No sense of belonging

Being misunderstood results barriers in relationship

Depression makes it hard to communicate with strangers

Blames one person for not being able to trust the community

Tests are not real world

Performing

Understanding of how to play along

Intentional lying in interview

Looking for someone to collude with self-deception

Carefully chosen degree of honesty

Concerned to demonstrate change

Ability to function practically

Intentional withholding of truth

Superficial relationships are easy

Exposure of performance leads to reality check

Presentation of self as performance

Manipulating the system

Choosing unreality

Self-deception

Categorising others and self

Capitulating (accepting subordinate status)

Impossibility of situation

Believing that positive change was too hard or impossible

Resigned to situation

Accepting illness equals hopelessness

Not knowing how to be helped

Wanting others to save her

Perceiving judgment from professionals

Equality in community versus hierarchy in services

Fears not realised, being listened to

Risking honesty and being believed

Learning to trust others

Helpful therapeutic relationship established

Freedom to disagree or clarify

Feeling believed by another person

Relationship formed through support

Felt believed and assured by interview

Accepted for who I am

Being believed established therapeutic relationship

Non-judgmental

Finding freedom

Feeling valued

Fears Realised but faced

Not believing in permanent positive change

Ups and downs are hard

Being offered treatments that gave no hope of change

Desperate for some hope or life

Not believing in the difficulty of the journey

Making relationships is hard

All in one place

Choosing reality

Finding Community

Self-awareness

Community has been a life-saver

Finding safety

Diagnosis helpful

Finding hope

Connectivity to something real

All in one place

Supportive environment

Relationship formed through support

Value of hearing other people's stories

Non-judgmental

Choosing reality

Finding stability

Finding freedom

Difficulty joining an existing social community

Demonstrating listening to others

Value of hearing other people's stories

Other people's hope is attractive and infectious

Discovering ways of communicating

Mutual interests in relationship

Relationship formed through sharing in attractive beliefs

Putting relationship above selfish thoughts and acts

Realisation I am not the only one

Realising actions effect others

Believing in hope that others have

Connectivity to something real

Knowing we are valued

Shocked by reality

Choosing reality

Safety

Finding safety

Supportive environment

Non-judgmental

Being believed established therapeutic relationship

All in one place

Accepted for who I am

Finding stability

Choosing transparency

Choosing transparency

Concerned to demonstrate change

Self-awareness

Exposure of fear

Other people's hope is attractive and infectious

Admitting that self-hate and self-judgment are producing relationship difficulties

Believing in the hope that others have

Others believing in the process of positive change

Shocked by reality

Connectivity to something real

Finding Hope

Believing in the hope that others have

Community has been a lifesaver

Finding hope

Accepted for who I am

Positive lifestyle changes

Other people's hope is attractive and infectious

Ending of isolation in community

Discovering ways of communicating

Being believed established therapeutic relationship

Felt believed and assured by interview

Self-confidence growing

Experiencing positive change

Finding Freedom

Freedom to disagree or clarify

Using less coping mechanisms

Non-judgmental

Risking honesty and being believed

Exercising choice

Membership of community independent of interview

Chance to be different

Choosing to be in community

Finding freedom

Mutual Positive Relationship

Value of hearing other people's stories

Helpful therapeutic relationship established

Ending of isolation in community

Risking honesty and being believed

Other believing in the process of positive change

Realisation I am not the only one

Relationship formed through support

Become part of the milieu

Putting relationships above selfish thoughts and acts

Learning to trust others

Feeling believed by another person

Realising actions affect others

Exposure of performance leads to reality check

Accepted for who I am

Believing in the hope others have

Feeling valued

Empowering

Explaining taking responsibility for yourself is empowering

Shocked by the reality

Now or never feeling

Self-reflection

Chance to be different

Diagnosis helpful

Exercising choice

Discovering ways of communicating

Freedom to disagree or clarify

Choosing transparency

Choosing reality

Experiencing positive change

Self-awareness

Self-reflecting

Realisation I am not the only one

Admitting the self-judgment and self-hate are producing relationship difficulties

Self-awareness

Realising actions affect others

Self-reflection

Not believing in the difficulty of the journey

Explaining difficulty with paid staff

Diagnosis helpful

Self-awareness

Shocked by reality

Connectivity to something real

Finding safety

Non-judgmental

Realisation I am not the only one

Admitting self-hate and self-judgment affect others

Realising actions affect others

Finding hope

Self-confidence growing

Doubting

Difficulty in joining an existing social group

Fear of change

Fear change not lasting

Fear of connectivity with people

Expressing doubt about the community

Fear of unknown

Believing that positive change was too hard or impossible

Deceived by health professional

Categorising others and self

Excusing full commitment to community

Explaining difficulty with paid staff

Fear of being sectioned

Fear of not being believed

Fearing the consequences of that disclosure on the relationship

Feels falsely accused

Feels only been asked what staff want to hear

Loss of trust

Lost hope in the system

Not believing in permanent positive change

Not believing the professionals

Previous trust in doctor broken by collusion

Professionals catch you out

Accepting

Accepted for who I am

Diagnosis helpful

Feeling believed by another person

Feeling valued

Freedom to disagree or clarify

Knowing we are valued

Non-judgmental

Relationship formed through support

Risking honesty and being believed

Supportive environment

Belonging

All in one place

Become part of milieu

Choosing to be in community

Finding safety

Finding stability

Realisation I am not the only one

Autonomy

Discovering ways of communicating

Exercising choice

Experiencing positive change

Explaining taking responsibility for yourself is empowering

Self-awareness

Self-confidence growing

Self-reflection

Shocked by reality

Using less coping mechanisms

Positive lifestyle changes

Freedom to disagree or clarify